CAPM&R

ACMP&R

The Canadian Association of Physical Medicine and Rehabilitation

News Nouvelles

L'Association canadienne de médecine physique et de réadaptation

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2003 Annual Scientific Meeting
June 11-15, 2003
The Fairmont Hotel Macdonald
Edmonton, AB

La réunion scientifique annuelle - 2003
du 11 au 15 juin 2003
Le Fairmont Hotel Macdonald
Edmonton (Alberta)

FROM THE EDITOR

Jeff Blackmer, MD, MHSc (Bioethics), FRCPC

Jeff Blackmer

In my last editorial, I discussed the topic of the annual meetings and where they are held. In this issue, the focus is on the upcoming CAPM&R meetings in Edmonton, Alberta from June 11-15. Thanks to Nigel Ashworth and his Department for their assistance both in preparing for the meetings and for their much appreciated contributions to this edition of the newsletter.

I ended my last editorial with a mention that often, projects and ideas that are conceptualized at the annual meetings do not reach completion. Perhaps this is as good a time as any to discuss why it might be that this happens and what, if anything, can be done about it.

The annual meetings, as we all recognize, provide an ideal opportunity to participate in networking. It is perhaps the one time every year when we have direct access to like-minded colleagues who are engaged in the same clinical work as we are. This provides the chance to discuss not only clinical issues but, more often, research, administrative and educational ones as well. Areas of common interest are identified, plots are hatched and plans made. That multi-centre trial you always wanted to do but didn't know if it was possible? Well, someone in Winnipeg is keen on the idea, so why not try and make a go of it? That educational session you keep meaning to set up for your residents? Turns out someone in Halifax has been thinking along the same lines and would like to collaborate. And the list goes on.

We leave the meetings with business cards in tow, new email addresses beamed into our Palm Pilots and visions of collaborative glory dancing in our heads. On the flight home we tell our local colleagues about these wonderful alliances we have struck and how they will benefit our department. We have only the very best of intentions on following through.

Then we get back to the office. We have 176 emails, half of them marked "Urgent". The pile in our inbox is measuring out at 17.5 inches in height. Our kids are finishing school soon and summer vacations are about to start. Our clinical workload is further increased when a colleague departs for greener pastures. We are asked to assume some new administrative responsibilities. Again, the list goes on.

In short, day-to-day life and the reality of clinical practice start to intrude on our plans made only a few weeks ago. Or maybe it actually takes a couple of months until this happens. Before we know it, it is June again and we are in a new resort community somewhere in Canada, saying: " Remember that great idea we had last year to develop a really innovative station for the residents' OSCE exam? Did you ever get around to that? Yeah, me neither. But maybe *this* will be the year."

Obviously, some of these projects do come to fruition and some really terrific collaboration does occur throughout the year. But I suspect, through my own personal experience and in speaking with numerous colleagues, that more often than not the above scenario, or something similar, comes to pass.

The reasons for this are obvious – people simply become busy, sometimes overwhelmed, by the workload they left and have to come back to, and there is precious little time to follow through on new projects. This may be especially true when they involve colleagues with whom we are not in contact on a day-to-day basis. It is easier to gain and keep momentum on a project when we are doing it

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with someone at our own center, since we see them often and there is also some greater sense of responsibility perhaps.

So what, if anything, can we do about all this? Perhaps not too much – a lot of these issues stem simply from the reality of academic and clinical life. However, as with any project, it may be helpful to set out some firm but realistic deadlines before leaving the meetings, to give the collaborators something to aim for. For example, I will email you a copy of a draft of the new exam station by August 15th, and you will make comments and changes and return it to me by September 15th. We will both put these deadlines in our schedulers and ask our staff to remind us about them. Or, we will set a specific time and date for a phone conference to discuss our grant proposal. Firm plans and dates might increase the probability of follow-through, but should probably be arranged before departing the meetings.

Involving one or more local colleagues in the plan might also be helpful – this will increase the sense of responsibility and perhaps accountability. Having monthly phone calls between all involved participants will also increase follow-through.

In short, there is no sure-fire way to ensure the success of projects planned at the annual meetings, despite having the best of intentions at the time. But even if only one of ten ideas actually ends up becoming reality, this may still be a fair return on the costs of participating in the conference. After all, think of all the projects you discuss with local colleagues that never come to pass.

See you in Edmonton!

LE MOT DE LA RÉDACTION

Jeff Blackmer, médecin, M.Sc. (bioéthique), FRCPC

Dans le dernier éditorial, j'ai abordé le sujet de l'assemblée générale annuelle et des lieux où elle se tient. Dans le présent numéro, l'accent porte sur la prochaine assemblée de l'ACMP&R à Edmonton (Alberta) du 11 au 15 juin. Je remercie Nigel Ashworth et son équipe de leur collaboration à la préparation de l'assemblée et à l'élaboration du contenu du présent numéro du bulletin d'information.

J'ai terminé le dernier éditorial en mentionnant que souvent des projets et des idées naissent à l'assemblée annuelle mais en restent là. Le moment est peut-être opportun pour examiner ce phénomène et voir s'il est possible d'infléchir la tendance.

Nous sommes les premiers à admettre que l'assemblée générale annuelle est une excellente occasion de réseautage. C'est sans doute le seul moment de l'année où nous avons la possibilité de rencontrer des collègues qui partagent des intérêts communs et dont les activités professionnelles sont semblables aux nôtres. C'est ainsi que nous avons la possibilité d'aborder non seulement des questions d'ordre clinique, mais également, voire plus fréquemment, des aspects relatifs à la recherche, à l'administration et à l'éducation. Nous cernons des domaines d'intérêt commun, nous posons des hypothèses et nous échafaudons des plans. Cet essai clinique multicentrique que vous avez toujours voulu entreprendre mais que vous croyiez impossible ? Eh bien, un collègue de Winnipeg est enthousiaste à cette idée, alors pourquoi ne pas tenter le coup ? Cette session éducative à laquelle vous pensez depuis un bon moment déjà pour vos résidents ? Vous découvrez que quelqu'un à Halifax a la même idée et aimerait bien unir ses efforts aux vôtres. Ce ne sont là que quelques exemples parmi de nombreux autres.

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Après l'assemblée annuelle, nous revenons chez nous armés de cartes professionnelles, d'adresses de courrier électronique notées dans notre ordinateur à main et de glorieux projets de collaboration en tête. Pendant le vol de retour, nous confions à nos collègues ces magnifiques alliances conclues et les avantages qu'en retirera le département. Nous sommes convaincus que nous mènerons à bien ces entreprises.

Puis, c'est le retour au travail. Nous attendent 176 courriels, dont la moitié ont un caractère « urgent ». La pile de dossiers à examiner fait 40 centimètres de hauteur. Les enfants auront bientôt fini l'école et les vacances estivales s'annoncent. La charge de travail s'alourdit au départ d'un collègue qui quitte pour mieux semble-t-il. On nous demande de remplir d'autres fonctions administratives. Ce ne sont là que quelques exemples parmi de nombreux autres.

En bref, le quotidien et la pratique clinique interfèrent soudainement avec les plans élaborés peu de temps auparavant. Il se peut que quelques mois passent avant que nous nous rendions compte que, par la force des choses, nous n'avons pas donné suite à nos projets. Avant que l'on s'en aperçoive, juin est là de nouveau et nous nous retrouvons dans un lieu de villégiature quelque part au Canada en train de dire : « Qu'en est-il de ton idée lumineuse de l'an dernier de mettre au point un scénario véritablement novateur en vue de l'examen ECOS des résidents ? As-tu pu la mettre en pratique ? Moi non plus. Mais je le ferai *cette* année. »

Bien entendu, certains projets voient le jour et des initiatives de collaboration fructueuses sont entreprises au cours d'une année. Mais, d'après mon expérience et celle de nombreux collègues avec qui j'ai abordé le sujet, ce que je viens d'évoquer se produit plus souvent qu'autrement.

La raison est simple : la charge de travail qui nous attend au retour gruge tout notre temps, et il paraît inconcevable de consacrer le peu qui nous reste à de nouveaux projets. Cela est d'autant plus vrai lorsque les initiatives ont été conçues avec des collègues que nous voyons rarement. C'est plus facile de maintenir l'enthousiasme initial lorsque nous collaborons avec une personne de notre centre, puisque nous pouvons la voir souvent et que nous nous sentons probablement tenus de donner suite au projet dans ce contexte.

Que pouvons-nous faire, s'il y a lieu, pour changer cette situation ? Peut-être pas grand-chose – pour beaucoup, la situation tient à la réalité de la pratique universitaire et clinique. On peut tout de même proposer d'établir un calendrier d'exécution, ferme mais réaliste, avant la fin de l'assemblée annuelle, de sorte que les collaborateurs ont des objectifs à atteindre. Par exemple, j'enverrai par courrier électronique la version préliminaire du nouveau scénario d'examen d'ici le 15 août, et, de votre côté, vous m'enverrez vos observations à ce sujet d'ici le 15 septembre. Nous inscrirons tous les deux ces dates dans notre agenda et demanderons à nos adjoints de nous les rappeler. Ou bien, nous fixerons une date et un moment précis pour tenir une téléconférence au sujet de notre demande de subvention de recherche. Des plans et dates précis peuvent augmenter la probabilité de donner suite au projet en question, et ils devraient être déterminés avant le départ de l'assemblée annuelle.

Il peut se révéler utile de demander la participation d'un ou de plusieurs collègues de l'endroit où nous pratiquons – cela pourrait accentuer notre sentiment de responsabilité et d'imputabilité. Organiser un appel téléphonique mensuel entre tous les participants pourrait également être un moyen d'assurer la suite des choses.

Bref, il n'y a aucun moyen qui garantisse la réussite des projets planifiés à l'assemblée annuelle, malgré les meilleures intentions du monde. Néanmoins, si seule l'une des dix idées ayant jailli à une assemblée est mise en pratique, on pourrait considérer qu'il s'agit là d'un bon rendement du capital investi pour participer à l'assemblée. Après tout, bien des projets évoqués avec des collègues de notre collectivité n'ont jamais franchi l'étape de la conception.

Au plaisir de vous voir à Edmonton !

PRESIDENT'S MESSAGE

Joanne Bugaresti, MD

This is the final newsletter message from your current president. As our 50th anniversary year comes to a close, I would like to give you a brief update of Association activities, thank you all for your tremendous support and hard work over the past two years and leave you with some future opportunities to consider.

Joanne Bugaresti

Firstly, we continue to receive reports regarding CPD. The participation rate in 2002 for active physiatrists was 93%. Thank you to Denyse Richardson-Gerek for her expert direction and support through the introduction of this new program.

We have volunteered to participate in the Health Technology Working Group of the Committee of Affiliates, Canadian Medical Association. The goal of this group is to establish a national plan and a structure for the acquisition and management of health technology in Canada. Our input to date has concerned the broadening of the understanding of technology from that of diagnostic services alone to the incorporation of therapeutic and supportive care equipment. As a member of the Committee of Affiliates of the CMA, we have not only contributed to the development of motions brought to counsel, but we have also benefited from the association through identification of expert legal advice and support re: contracts.

As a member of the newly formed National Specialty Societies Group, we have shared information about our structure, organization and finances with other specialty groups. A web site now exists to support interactions within this group. Over the next year, we will be exploring potential advantages of common needs across specialties. An example of potential benefits may include the negotiating advantage with economies of scale. Collectively, members of the NSS book an estimated 24,000 hotel nights per annum for conferences.

With the able assistance of Dr. Brenda Joyce, the publications of R J O'Connor, R S Mortifee and R Milner and your timely responses to the human resource planning questionnaire circulated this spring, a report was presented on your behalf to Task Force II regarding physiatry demographics, human resource needs, models of care and future planning. A copy of this report and of the summary data from the survey this spring will be available at the annual meeting in Edmonton. We identified approximately 30 vacant positions in physiatry across the country. The first publication of Task Force II entitled *Physician Workforce in Canada: Literature Review and Gap Analysis* is now available on the web. One of the key messages of this report is the need for planning at the national level. There is an interest in research-examining skills needed for collaborative team health delivery and a desire for accessible data, which would aid needs based assessment.

Upcoming events include the 2004 meeting in PEI, 2005 in Ottawa. Canada is a site of interest for 2005 with both the executive of ISPRM and the National Action Network for the Bone and Joint Decade looking to Canada to host meetings. We have yet to determine our involvement in either of these opportunities.

As you are aware, we have recruited Irene Lange-Mechlen to assist us with marketing our Association and fundraising in the upcoming year. She will be at the annual meeting, and I hope you will take the time to identify yourself and speak with her about your interests.

I have greatly appreciated the opportunity to represent CAPM&R in a variety of forums over the past two years. The experience has given me an enhanced appreciation of physiatrists and our Association. By virtue of our members

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and our affiliations, we have the opportunity to influence national health policies, directions in research and education and health service delivery. As you take the opportunity to seek a committee chair position or nomination to the Board, I suspect you will also enjoy the friendly collaboration of our members in furthering the interest of physiatrists both on and off the golf course.

In closing, Dr. Tardif has challenged us to support the Foundation. While he has requested a tidy sum, any contribution you make, in time to CAPM&R or in dollars to the Foundation will contribute to the advancement of physiatry through networking, or education and research. All contributions are welcome and appreciated.

I would again like to thank our membership, our committee chairs and our executive for their ongoing commitment to the Association and its mission.

MESSAGE DE LA PRÉSIDENTE

Joanne Bugaresti, médecin

Voici mon dernier message à paraître dans le bulletin d'information. En cette fin d'année du 50e anniversaire, j'aimerais faire brièvement le point avec vous sur les activités de l'Association, vous remercier tous de votre appui indéfectible et des efforts déployés au cours des deux dernières années, et terminer en abordant certaines perspectives d'avenir.

D'abord, nous recevons toujours des comptes rendus au sujet du PPC. En 2002, le taux de participation des physiatres en pratique active est de 93 %. Je souligne ici la contribution experte de Denyse Richardson-Gerek à la direction et à l'introduction de ce nouveau programme.

L'Association s'est portée volontaire pour participer au Groupe de travail sur la technologie du Comité des sociétés affiliées de l'Association médicale canadienne (AMC). Ce groupe a pour objectif d'établir un plan et une structure d'envergure nationale d'acquisition et de gestion de la technologie de la santé au Canada. Jusqu'à maintenant, nous avons contribué à élargir la définition de technologie, qui ne couvrait initialement que les services diagnostiques, afin qu'elle s'étende à l'équipement thérapeutique et à l'équipement nécessaire aux soins de soutien. À titre de membre du Comité des sociétés affiliées de l'AMC, nous n'avons pas seulement participé à l'élaboration de motions présentées au conseil, mais nous en avons également retiré des avantages sur les plans de la consultation juridique et du soutien en matière d'ententes de services.

En tant que membre du Groupe des associations nationales de spécialistes (ANS) de formation récente, nous avons échangé de l'information sur notre structure, notre organisation et nos finances avec d'autres associations de spécialistes. Un site Web a été créé pour faciliter les interactions au sein du groupe. Au cours de l'an prochain, nous étudierons les avantages potentiels liés à la mise en commun de nos besoins. À titre d'exemple, il pourrait s'agir du levier de négociation que constituent les économies d'échelle. Dans l'ensemble, les membres des ANS réservent environ 24 000 nuitées à l'hôtel par an à l'occasion des conférences.

Grâce à la participation experte du Dr Brenda Joyce, aux publications de R J O'Connor, de R S Mortifee et de R Milner, et à votre empressement à répondre au questionnaire sur la planification des ressources humaines distribué ce printemps, un rapport a été présenté en votre nom au Groupe d'étude II concernant les

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caractéristiques démographiques, les besoins en ressources humaines, des modèles de prestation de soins et la planification future en physiatrie. Ce rapport et le sommaire des données compilées du sondage de ce printemps seront disponibles à l'assemblée générale annuelle à Edmonton. Nous avons ainsi relevé environ 30 postes vacants en physiatrie au pays. La première publication du Groupe d'étude II, intitulée *Physician Workforce in Canada : Literature Review and Gap Analysis*, paraît dans le Web. L'un des principaux éléments du rapport concerne la nécessité de planifier à l'échelle nationale. On dénote également un intérêt à l'égard des compétences en recherche-examen nécessaires à la prestation des soins en mode concerté et un désir de rendre l'information accessible pour faciliter l'évaluation fondée sur les besoins.

Au chapitre des activités à venir, mentionnons l'assemblée de 2004 à l'Île-du-Prince-Édouard et celle de 2005 à Ottawa. Plusieurs ont les yeux tournés vers le Canada en 2005, comme en témoignent les démarches préliminaires du Comité de direction de l'ISPRM et du *National Action Network for the Bone and Joint Decade* en vue de leur assemblée. Nous ne savons pas encore dans quelle mesure nous participerons à ces activités.

Comme vous le savez sans doute, nous avons retenu les services d'Irene Lange-Mechlen qui se chargera du marketing de l'Association et de l'organisation d'activités de collecte de fonds au cours de l'année. Elle sera présente à l'assemblée annuelle, et je vous invite à la rencontrer et à lui faire part de votre opinion.

Cela a été un honneur de représenter l'ACMP&R à diverses occasions au cours des deux dernières années. J'ai pu ainsi mieux connaître les physiatres et notre Association. Fort de l'adhésion de nos membres et des alliances formées avec d'autres groupes, nous sommes en mesure d'influencer, à l'échelle nationale, la politique de la santé, les orientations en recherche et en éducation et la prestation des soins de santé. D'ailleurs, tous ceux qui siégeront à un comité ou au Conseil bénéficieront également de la collaboration amicale des membres dans la défense des intérêts des physiatres, sur un terrain de golf ou ailleurs.

En terminant, le Dr Tardif sollicite notre soutien à l'égard de la Fondation. Même si son objectif est d'amasser une somme assez considérable, n'importe quelle contribution, que ce soit en temps ou en argent, favorisera l'avancement de la physiatrie grâce au réseautage, à l'éducation ou à la recherche. Inutile de dire que nous réserverons un bon accueil à toutes les contributions, peu importe leur ampleur.

Je tiens à remercier de nouveau les membres, les présidents de comité et la direction de leur engagement continu envers l'Association et sa mission.

PRACTICE PROFILE

DIVISION OF PHYSICAL MEDICINE AND REHABILITATION, UNIVERSITY OF ALBERTA, GLENROSE REHABILITATION HOSPITAL FACULTY

Nigel Ashworth, MD

Fifteen physiatrists are actively involved currently in the Rehab Academic Center based predominantly at the Glenrose Rehabilitation Hospital (GRH) in Edmonton. The GRH is a free standing tertiary rehabilitation center with approximately 250 inpatient beds, numerous outpatient programs, state of the art facilities and a large catchment area that includes Northern Alberta, the Northwest Territories, and parts of Saskatchewan and British Columbia. Clinical care covers the full continuum of age groups from neonatal through to geriatric and a wide variety of diagnostic groups. The GRH has a strong commitment to rehabilitation research and teaching. As such the physiatrists are heavily involving in many aspects of undergraduate, postgraduate and interdisciplinary teaching. We also have strong research links with other university faculties and departments (such as the Faculty of Rehabilitation Medicine, Faculty of Physical Education and Recreation, Division of Rehabilitation Neuroscience and others) that covers the spectrum of research from basic science research through to clinical and epidemiological.

Academic Faculty

Nigel L. Ashworth, MB ChB, MSc, FRCP(C) (Associate Professor and Head). Dr. Ashworth graduated in 1989 from the University of Leicester Medical School, UK. He has traveled widely and worked in Barbados, New Zealand and the UK before completing his PM&R residency at Dalhousie (rotating internship) and Saskatchewan. He obtained a Masters degree in Community Health and Epidemiology at the University of Saskatchewan and started on academic staff there in 1997. In 1999 he became the Academic Department Head and Clinical Head in 2000. In 2001 he moved to his current position at the University of Alberta. In Edmonton he is also the Regional Clinical Director of Rehabilitation for the Capital Health Authority. The majority of his time is spent in research activities and teaching, with particular interests in neurorehabilitation, epidemiology of disability and clinical neurophysiology.

Lalith Satkunam, MB BS FRCP(C), (Residency Program Director and Associate Professor) graduated from the University of Peradeniya, Sri Lanka in 1984. Completed a teaching fellowship in Anatomy at the University of Alberta in 1991. He went on to complete his residency in PM&R at the University of Saskatchewan in 1995. Certification in Electrodiagnosis with Canadian Congress of Neurological Sciences and American Association of Electrodiagnostic Medicine. Areas of interests include electrodiagnosis, brain injury rehabilitation, spasticity management and teaching.

K.Ming Chan, MD FRCP(C) (Research Director and Associate Professor) graduated from Glasgow University in Scotland in 1984. He went on to complete his residency training in PM&R at the University of Alberta in 1993 and then completed a neuromuscular clinical and research fellowship at Tufts University, Boston, MA. Dr. Chan's clinical interests include neuromuscular diseases; his research interests include effects of aging and disease on motor functions in humans. Further details are available on his web page: http://www.ualberta.ca/~kming/homepage.htm

Jackie Hebert, MD FRCP(C) (Assistant Professor) graduated from the University of Calgary Medical School in 1995. She completed her residency in PM&R at the University of Alberta in June 2000. She is the Clinical Director of the amputee program at the Glenrose Rehab Hospital. Areas of special interest include rehabilitation of persons with amputation, electromyography, and musculoskeletal rehabilitation.

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Tessa Gordon, PhD (Professor) graduated from the University of Cape Town with a BSc in Physiology and Psychology, followed by a MSc and PhD in Physiology from University of Birmingham, UK. She was appointed as Alberta Heritage Foundation for Medical Research Scientist in 1992 and Senior Scientist in 1997. She joined the Physical Medicine & Rehabilitation Division in March 2003. Her research interests are in peripheral nerve, skeletal and cardiac muscle physiology, pharmacology and molecular biology particularly in relation to plasticity during development, injury or under exercise conditions.

Shawn Gray, MD, PhD (Associate Professor) graduated from the University of Calgary with a BSc then MSc in Psychology in 1977. He obtained his PhD in Biopsychology from UBC in 1981. In 1985 he obtained his MD from the U of Calgary and practiced as a family doctor for a number of years before entering the PM&R residency program at the U of Alberta in 1997. He is currently the Medical Director and Chief of Service of the Brain injury rehab program at the Alberta Penoka Hospital and an associate professor in the division of PM&R. His research interests are in the area of Psychopharmacology of brain injury.

Clinical Faculty

Robert Burnham, MSc MD FRCP(C) (Clinical Associate Professor) graduated from the University of Alberta Medical School in 1980. He also completed his training in PM&R at the University of Alberta, finishing in 1986. Dr. Burnham's interests include: MSK rehab, electrodiagnosis and research.

Mario DiPersio, MD FRCP(C) (Undergraduate Program Director and Clinical Assistant Professor) graduated from Dalhousie University Medical School, Halifax, Nova Scotia in 1988. Dr. DiPersio also completed his residency in PM&R at Dalhousie in 1997. His clinical interests include inpatient and outpatient pediatric rehabilitation, adult stroke rehab and independent medical examinations.

John B. Guthrie, MD FRCP(C) (Clinical Associate Professor) Dr. Guthrie is a diplomat of the American Board of PM&R. He is American Board Subspecialty certified in spinal cord injury medicine and is the Clinical Director of the spinal cord injury/general neurology program at the Glenrose Rehab Hospital. Clinical interests include spinal cord injury and other neurological rehabilitation, as well as orthotics.

Julianna M. Nagy, MD FRCP(C) (Clinical Associate Professor) graduated from the University of Calgary Medical School in 1982. She completed her residency training in PM&R at the University of Alberta in Edmonton and did a Fellowship in Pediatric Rehab at Tufts University, New England Medical Centre in Boston, MA. She is the Clinical Director of the brain injury program at the Glenrose Rehab Hospital. Dr. Nagy's clinical interests include brain injury rehab and pediatric rehab.

Evan E. Sampson, BMedSc MD FRCP(C) (Clinical Assistant Professor) Dr. Sampson graduated from Medical School at the University of Alberta in 1993 and continued on to receive his training in PM&R in 1998. Clinical interests include MSK, EMG, soft tissue pain disorders and post-polio.

Judy Townsend, MD FRCP(C) (Clinical Assistant Professor). Dr. Townsend graduated from the University of Calgary in 1994. She completed her training in PM&R at the University of Alberta in 1999. She is the Clinical Director of the Musculoskeletal program at the Glenrose Rehab Hospital. Clinical interests include: MSK and EMG

Carmen Tuchak, BSc(Hons) MD FRCP(C) (Clinical Assistant Professor). Dr. Tuchak graduated from Medical School at the University of Calgary in 1994. She then went on to complete her training in PM&R at the University of Alberta in 1999. Clinical interests include neuro rehabilitation including stroke, MS, adults with physical disabilities, and spinal cord; sexuality in the disabled and

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regional musculoskeletal pain and dysfunction. She is the Clinical Director of the Stroke program at the Glenrose Rehab Hospital. Research interests are in functional outcomes after stroke.

Ervin Veszpremi, MD FRCP(C) (Clinical Associate Professor) graduated from the University of Medical Sciences, in Debrecen Hungary in 1957. He received his PM&R training in Edmonton, Alberta. Dr. Veszpremi's clinical interests include spinal cord injury, stroke and musculoskeletal rehabilitation.

Joe M. Watt, MB BS FRCP(C) (Clinical Professor) Dr. Watt also holds positions as Clinical Professor in the Department of Pediatrics at the University of Alberta. He received his medical training at the University of Hong Kong and his training in PM&R at the University of Toronto. He also completed a Fellowship in Pediatrics at the University of Alberta. Dr. Watt's clinical interests include cerebral palsy, acquired brain injury, spina bifida, neuromuscular disorders in children and pediatric EMG. Research interests include pediatric acquired brain injury, gait analysis and infant motor development.

L. Anne Bellamy, MD FRCP(C) (Clinical Professor) Dr. Bellamy graduated in 1973 from the University of Alberta Medical School. She completed her residency training in PM&R at the University of Alberta and the University of Toronto, receiving her FRCP(C) in 1977. Dr. Bellamy has a particular interest in stroke rehabilitation and outcome measurement. Clinical interests also include neurologic and MSK rehabilitation.

EDUCATION CORNER

THE MYSTERY OF THE "PLP"

Sue Dojeiji, MD, MEd, FRCPC

What, you may ask, is a PLP? No, it's not a trendy veggie sandwich or a fragment of genetic material. A Personal Learning Project (PLP) is a great way to achieve Maintenance of Certification (MOC) hours and credits.

In 1998, the Council of the Royal College of Physicians and Surgeons of Canada (RCPSC) passed a motion making MOC participation mandatory for all Canadian Specialists. This motion allows Specialists to demonstrate and prove competence in their specialty. It is a requirement for the designation of ***Fellow***.

Most of us are now familiar with the process of acquiring our 400 credits in 5 years and the 6 Continuing Professional Development (CPD) options to do so. However, as MOC organizer for our Division, most of the questions I receive relate to the mysterious PLP.

In the CPD framework, the PLP is an example of Section 4 activity – Structured Learning Projects. These are activities that are planned and the outcome is recorded and evaluated. Physicians receive 1 credit per hour of activity, with no maximum. Other activities in Section 4 include Traineeships, Fellowships and Masters or PhD programs. This article will focus on the PLP.

A PLP is any learning activity initiated by a physician. The PLP reflects and prioritizes the individual physician's learning needs. This type of learning is referred to as practice-based learning where physicians take a more systematic and critical approach to their professional development.

There are 4 components to the PLP:

1. The physician identifies a question, controversy, innovation or idea that is applicable and significant to his/her

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practice. This question may arise from regular journal reading, attending educational rounds/conferences, supervising a trainee or from day-to-day practice (most common). This step is critical in identifying the learner's needs (a potential gap between current knowledge and desired practice).
2. The physician documents the stimulus for the question – where did the question come from (readings, practice etc…).
3. The physician indicates the references used to obtain the answer to the question. References can be discussions with colleagues/experts, literature searches, journal readings, conferences and so forth.
4. The physician documents the outcome of learning and the impact to practice (*"Am I up-to-date?", "Am I convinced to initiate a change in my practice?"*). Sometimes, no change in practice occurs. The answer served to confirm that the physician was up-to-date.

The process seems intimidating, but it is no different than what most of us have been doing for years. We see something of interest; we explore the literature, speak to colleagues or local/national experts at meetings or in hallways; finally, we decide if we continue as before or change something in our practice based on the new information we acquired. The only difference now is that we have to document this process of practice-based learning to obtain credit and prove our commitment to life-long learning.

Documentation of the PLP should not be an onerous task. Using the four outlined steps, physicians can document their learning in many ways:

- In their paper agendas.
- Loose paper in a PLP file/binder (you must be organized to do this!).
- Personal digital assistant (PDA) like Palm ™ – RCPSC website contains information on programs that can assist with this.
- PC Diary – easiest way to do this! Simply go to www.mainport.org. You will need your RCPSC ID number to log on. Your password is your last name in upper case letters. Click onto Web Diary, then click PLP to document your project. You can go back at any time to update the page once your search is over.

Here is an example of one of my PLPs. In February, I attended the University of Ottawa PM&R Research Day. Here is the process I used to document my time:

1. **The Question**: What's new in PM&R research?
2. **The Stimulus**: As an academic Physiatrist, I wanted to see the type of research that engaged my colleagues. Also, I wanted to seek out collaborators for my research and educational interests.
3. **The References/Resources**: I attended a one day Research Symposium given by the University of Ottawa Academic Physiatrists and Residents (6 hours), and I had discussions over dinner with colleagues regarding research pursuits and potential topics (1 hour)
4. **The Outcome**: I documented the day's events on the Research Symposium's Program. I listed one research idea that I wanted to pursue in the next year with a contact person/potential collaborator. I put the summary sheet in my MOC binder, because I too forget my RCPSC number; and, sometimes it is easier to keep the paper trail.

Many sources exist for PLPs. The RCPSC website contains all you need to know. Also, the CAPM&R CPD Committee, headed by Dr. Denyse Richardson, is another invaluable resource. Dr. Richardson will present an update on MOC at the upcoming CAPM&R meeting in June.
See you in Edmonton!

References

1. www.rcpsc.medical.org
2. www.mainport.org
3. Maintenance of Certification: Information Guide for Fellows – available from Royal College to new Fellows
4. Campbell, C. Making the Most of Personal Learning Projects. Annals RCPSC, vol. 33, number 6, p.399-400.

ROUND THE WORLD CHALLENGE
Part II

Mike Nemesvary

Despite all the politics and controversy that besieged and delayed the eventual construction of the Chunnel between the UK and France, it's quite the experience. In my many years as a World Cup freestyle skier, I had the opportunity to travel on numerous ferries across the English Channel from many various ports and I can attest that the Chunnel is the way to go. Essentially, you drive your vehicle into a sort of boxcar, which is part of a long train, and the doors are automatically sealed. Forty minutes later, you are in France. Of course, you have to forego the views of the Channel, feeding the seagulls and cafeteria snacks, but hey, it saves two hours!

Getting to France was symbolic as it represented the next major leg of the journey. We started booting along the French autoroutes at approximately 120-125 km per hour trying to make some time. Originally, we had planned to stay in Paris but at the last moment we decided to change our plans and opted to take the circular road around the city and see how far we could get that day. It was the Easter long weekend and around 9 p.m. we decided to start looking for a place to stay. This was not easy as all the hotels we stopped at were either not accessible or not vacant. We would continue driving for hour after hour to lots of little French towns off the autoroute and encounter the same problem over and over again. We would ask for recommendations, get one down the road and then run into the same situation. On one occasion, we pulled into a hotel that was part of a major chain in Europe and pleaded with this lady (Night Manager) for accommodations … a floor, a couch, anything! But she was reticent and eventually said "Excuse … no." We decided to make a major push: two more hours into Dijon (like the mustard). What a beautiful little city with the river running through it. We got to yet another hotel and fortunately got their very last room. All three of us stayed in the equivalent of a "broom cupboard." But, we were so tired that we just crashed at around 4 a.m. … no bath, no meals, no conversation, just sleep, beautiful sleep!

The next day we woke at 11 a.m. and had one of the best meals of the whole trip. It was a set menu for the Easter weekend. It was like food sex, a five-course meal! It represented the whole trip in a microcosm …adversity management punctuated with delightful experiences. We then pushed on to the seven-hour haul to Basel, Switzerland. We met with Mike Abson, a good friend and my former coach who helped me get into the sport of freestyle skiing in the first place, and his new wife Esther. He had become quite successful in the corporate world as president of Swatch Canada amongst other prestigious positions. Not bad for a guy who dropped out of high school in grade 10! Some of the highlights of the trip were getting the chance to meet up and hang with good old friends. It is interesting to note that I have gone to see them much more than they have come to see me. What does that say? That evening we had a really nice traditional Swiss dinner with my friends in their large, comfortable pad on the mountainside just outside of Basel.

After a relaxing three days, we departed Mike and Esther's place en route for the Swiss National Rehabilitation Centre located outside the small town of Nottweil, approximately one hour from Basel. Mike, Esther and many of my old skiing buddies had spent the past few weeks organizing the visit to the premiere rehabilitation hospital in Switzerland and one of the leading facilities in the world. These friends included Danny Neith, Sonny Schonbichler (1994 Olympic Gold Medalist in Men's Aerials), Evelyn Wirth and Conny Kissling.

Upon arriving at the front doors to the "Schweizer Paraplegiker Zentrum" facility reminded me more of checking into the "Hilton Hotel" with it's large circular entrance, grand reception area and vast open spaces … not your typical hospital looking facility! We were

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met by the chief medical doctor, Dr. Dieter Michel, a very kind and knowledgeable man who escorted the team and I around the centre. It was a treat to see first hand how advanced their holistic approach to rehabilitation was. From basic and applied research to patient care to sports, recreation and research ... it was a first class facility. One other thing that really stood out for me was seeing the large private rooms that overlooked the pristine gardens on the shores of the lake and the mountains in the background. If you have to sustain a spinal cord injury, Switzerland is the place to do it! I was also informed that Swiss paraplegics or quadriplegics receive $100,000 (S.F.) approximately $50,000 (CND) following their injury, in addition to all their medical care covered by the state.

Following our tour, we were invited for a private lunch with the Swiss national media, friends and hospital representatives. Also in attendance was the founder and President of the Centre, Dr. Guido A Zach. He was an extremely wise, humble and kind man who went out of his way to share his warm hospitality and generosity of spirit with us. I really enjoyed our brief discussions about living with a spinal cord injury, the future of research and rehabilitation and the importance of independence and mobility. He really understood the magnitude of the RWC (Round the World Challenge) and potential awareness/impact our project could generate worldwide. Just as we were leaving to give a lengthy interview to the Swiss National TV Station and “Blick”newspaper, Dr. Zach asked me to hold on for a few minutes while he rushed off to get something for us. Thinking he was coming back with a parting gift, we were pleasantly surprised to receive an envelope containing a cash donation of SF 5,000!

We then followed our Swiss friends in convoy around the picturesque lake for a much-anticipated dinner party and one night stay with my old skiing friend - former World Champion aerialist for Switzerland, Evelyn Schnorf Wirth. “Eve” as she was affectionately known as, was always one of the kindest and best-humoured athletes on the RWC Tour. She also wrote me some very heart-felt letters and cards following my injury. Eve had married well and now, as a mother and businesswoman, it was great to reconnect with her and see how her post-skiing life had developed. Eve had generously agreed to host a dinner party at her house overlooking the lake and proceeded to invite 15-20 of my old skiing friends who were on the Swiss team. As my old friends started showing up it was great to catch up on old times and find out what everyone was now doing with their lives. Without fail, everyone was very supportive of RWC and very impressed that I had come so far in spite of my disability. We ate and drank like it was the 80’s again and even tried to play the Alpine horns before finally hitting the sack in the early hours of the morning. We woke up early the next morning to some late season snow and headed on our way to Germany.

For those readers who have traveled in continental Europe, you know how quickly you can get from one country to another. Sure enough, by late afternoon we had arrived at our next destination: Munich, Germany. It was the first time my former partner, Christine had been to her father’s country of origin and she felt a strong sense of connection to her roots. For me, Germany and especially Munich held a special place in my memory. Munich was a city where I spent a great deal of time when I first started skiing for the British team. I was very good friends with Fuzzy (pronounced “Footsie”) and Ernst Garhammer and family. The Garhammers were quite a famous skiing family in Germany and quickly took me under their wing when I moved to Europe in my early 20’s. I starred in one of Fuzzy’s adventure ski movies entitled “Das Wunderski”(The Wonder Ski) as the Canadian cowboy. The movie was set in the Italian Dolomites where we did some heli-skiing and in the Sahara Desert in Morocco where we did some sand skiing and even rode a camel! I also coached at the Garhammer’s summer ski camps on the glaciers in Kaprun, Austria and Schnalstal, Italy. At one point they were amongst the largest and most popular ski camps of their kind in the world.

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Munich was also significant for me because it was the world headquarters for Bogner ski clothing … the most exclusive and expensive ski clothing in the world. Willie Bogner had sponsored me for four out of my five World Cup competitive years and gave me the opportunity to be one of the aerialists in the award-winning ski movie, “Fire and Ice”, starring my good friends John Eaves and Suzie Chaffee (the Chapstick girl on TV in the 70’s). Apart from being a hub for my various off-season skiing enterprises, Munich was a beautiful town with many historical sites, parks, rivers and off course, beer gardens. Most will know Munich to also be the home of “Okterberfest” which is not for the feint-hearted who can’t take their beer … like me, but that’s another story!

Shortly after checking into one of my favourite hotels in the world, the “Prinz Regente”, a five-star hotel with old country charm, decor and large king-size four poster wooden beds, my good friends, Fuzzy, Ernst and Willie all met us at the bar for a stein of beer. As I didn’t tell all parties who was joining us, I was taken back to learn that Fuzzy and Willie had had a falling out years ago and had not reconciled their feelings towards one another despite the fact that they were both now in their 60’s! We all headed out to have a Chinese meal and were joined by another Garhammer brother, Franzie, Sandro Wirth and Franzie Geiger. Unfortunately, Willie didn’t join us, but we had a great time reminiscing. We joked about my role as the Canadian cowboy and how we all thought it was going to be glamorous filming in Morocco for three weeks, only to learn we would be camping out for the entire duration! The next morning, Fuzzy showed up early to shoot some video and stills of us touring around the cities’ landmarks before we headed off to Italy via Austria.

It always amazes me how very small continental Europe is. Case-in-point, we drove through Austria in all of an hour (mind you, it was only the western tip). Going through the Brenner Pass we encountered very stormy conditions and actually drove through a snowstorm … in mid April! We got to the top of Brenner Pass, one of major mountain passes in all of Europe which connects the Tyrolean region with the lowland countries. The top of the pass is at nine thousand feet. From that point to sea level, it is a complete downward incline, through valleys, tunnels and bridges. It was an ultra glide for eight to nine hours. You have to be there to appreciate these roadways … it is an amazing feat of engineering. Out of the Alps, through the Dolomites mountain range and before you know it, you’re right in the heart of the Italian vineyards.

Going on 7 p.m. we made it to the most romantic city in the world, Venice. Fortunately, it was a nice time of the year to be in Venice, not too hot, not too smelly (substandard plumbing), not too many tourists. All in all, it was our best day of travel so far … we literally had breakfast in Munich and dinner in Venice. Oh, if only we knew the adversity ahead of us, we would have stayed in Venice for a month or two!

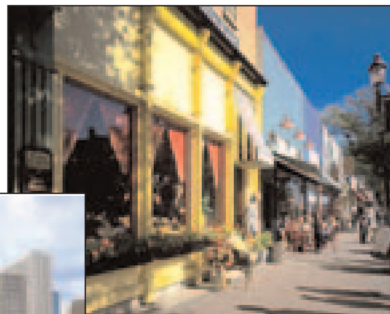
More to come in the next issue …

RESIDENT'S CORNER:

WHAT TO SEE AND DO IN EDMONTON

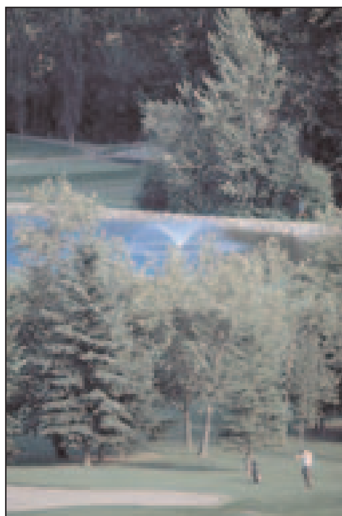
Michael Lang, MD

Summer is the best time of year in Edmonton, but don't blink or you'll miss it. Fortunately, late June is fairly reliable for good weather. Those of you visiting should try to bring an assortment of clothes to cover warm daytime and cool to cold evening temperatures.

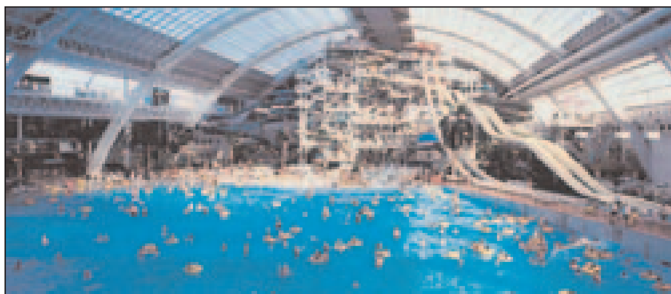


Right now, the best thing to do in Edmonton is going to see wild playoff Oilers hockey. Unfortunately for those visiting in June, it will all be done by then. Not to worry, there will be plenty to keep you busy and entertained, regardless of your interests.

Please be sure to enjoy a stroll down trendy Whyte Ave (82nd Ave). This popular street near the University is a local favourite for unique shops, cafés and restaurants. In the evening, the younger crowd comes out to enjoy the many pubs and dance bars.



The river valley runs through the middle of the city, dividing north from south. Enjoy a ride on the Edmonton Queen: a paddle boat with full service bar and restaurant. You can also get some fresh air and exercise on the many miles of hiking and bicycle trails throughout the river valley.



Photos: Edmonton Tourism/ Economic Development Edmonton

Golf enthusiasts will be happy about the many inexpensive and challenging public courses. There are quite a few, but if you want to play the ones in the city centre you should get a tee time a couple days in advance.

There are a number of wonderful restaurants throughout Edmonton. You can get great food on almost any budget. There are many cultural favourites so be sure to ask around to find the best spots.

Elk Island is a great camping/hiking/picnicking/golfing/drive through reserve about 45 minutes east of Edmonton. You will be sure to see elk and bison, and probably a moose or two as well.

Finally, what would a trip to Edmonton be without a visit to "the mall". West Edmonton Mall can easily consume a full day or more. Bring your bathing suit and your credit card. There are shops as far as the eye can see. There are food courts as well as excellent restaurants and nightclubs. Visit the water park or the amusement park. Watch the dolphin show and go for a ride in the submarine. Wind it up with a movie at the IMAX or Silvercity theatre (make sure you see the fire-breathing dragon in the lobby).

Oh yeah, I think there will be some sort of conference going on at the Hotel Mac as well. Those of you interested in more detailed advice, just visit www.whereedmonton.com

See you in June!

P.S. If you can manage it, take some extra time and visit the mountains. The experience is unforgettable.

Maintenance of Certification

SELF-ASSESSMENT PROGRAM

As an accredited provider, CAPM&R is able to accredit a SAE. The American Association of Electromyography Medicine SAE meets the criteria for an accredited SAE and anyone completing the SAE can accumulate the points in Section 3.

- **Steps for on-line submission**
- **Royal College - Maintenance of Certification site**

STEPS FOR ON-LINE SUBMISSION

Dear Colleagues,

The RCPSC Maintenance of Certification Program requires Fellows to submit proof of continuing education activities to maintain their FRCPC or FRCSC. You are required to collect 400 credits per five year cycle. You must have a 40-credit minimum in every year but one.

The filing deadline is January 31, 2004 for hours completed in 2003.

The steps for on-line submission:

A. Go to the Royal College web site, http://rcpsc.medical.org/

B. Insert your Royal College number and password. Your password is your last name in capital letters.

C. The main page has a dashboard on the left hand side of the screen to "submit CPD hours".

D. Choose the year for which you want to submit hours and you are now in the web entry form and you can start filling in your hours.

1. **Section 1 Activities:**
   i. Accredited rounds - One credit per hour. You can enter all the hours you have accumulated on an hour by hour basis. DOCUMENTATION - SUPPLIED BY THE PROGRAM PLANNING COMMITTEE AND MADE AVAILABLE TO FELLOWS ON REQUEST.
   ii. Accredited conferences, workshops, meetings - One credit per hour. Enter total number of hours attended. DOCUMENTATION - RECEIPT OF REGISTRATION (AS PRESENTLY REQUIRED FOR TAX PURPOSES) OR CERTIFICATE OF ATTENDANCE AND PROGRAM SCHEDULE OR AGENDA.

   Total these two sub-sections i) and ii). One credit per hour. No maximum.

2. **Section 2 Activities:** Other learning activities for reading journals, texts, non-accredited rounds - NO DOCUMENTATION NECESSARY. *
3. **Section 3 Activities:** Accredited Self-Assessment Programs. Two credits per hour with no maximum.
4. **Section 4 Activities:** Personal learning projects, traineeships, courses (e.g. masters, Ph. D, etc.). One credit per hour. No maximum.
5. **Section 5 Activities:** Practice audits and patient surveys. Two credits per hour with no maximum.
6. **Section 6 Activities:** Educational development for teaching and research talks, grant proposals, referee papers, writing articles, guideline development, referee grants.* One credit per hour.

* There is a maximum of 100 hours in sections 2 & 6 per five-year cycle.

When you've completed your filing, click on the "save" button. You can then visit your CPD Profile Summary by choosing that option from the dashboard. If you wish to make a change, return to the "submit CPD hours" page and add or subtract hours. To exit, click on "log out".

Please keep your documentation for your records. You do not have to submit them to the Royal College unless you are selected as one of the 3% to have your submissions validated as part of the Credit Validation Program.

If you have any questions, please contact:
RCPSC Information Centre
613-730-6243 or 1-800-461-9598
cpd@rcpsc.edu

CALENDAR OF EVENTS - ÉVÈNEMENTS À VENIR

If you have attended any of these meetings in the past and have comments for your colleagues, please contact the CAPM&R Secretariat at: capmr@rcpsc.edu

May 18-22, 2003
2nd World Congress of the International Society of Physical Medicine and Rehabilitation Medicine – ISPRM
Prague, Czech Republic
For more information:
www.kenes.com/physical

May 23-26, 2003
5th World Congress on Brain Injury
Stockholm, Sweden
For more information:
http://www.congrex.com/braininjury/
braininjury@congress.se

June 11-15, 2003
Canadian Association of Physical Medicine and Rehabilitation Medicine (CAPM&R) RehabNet Annual Meeting
Hotel Macdonald Edmonton, AB
For more information:
Email: capmr@rcpsc.edu
For Hotel information: Hotel Macdonald

June 14, 2003
Canadian Congress of Neurological Sciences
2003 Canadian Examination in Electromyography (EMG)
Edmonton, AB
For more information:
http://ccns.org/ccns_information/cscn/cscn_intro.html

June 15-18, 2003
Global Health Economics
Bridging Research and Reforms
4th World Congress
San Francisco, CA USA
For more information:
www.healtheconomics.org

June 17-21, 2003
38th Meeting of the Canadian Congress of Neurological Sciences
Quebec City, QC
For more information:
www.ccns.org

July 11-13, 2003
1st International Conference on Information Communication Technologies in Health
Samos Island, Greece
For more information: Regina Tsirka, Conference Administrative Director
ineag@otenet.gr
http://www.ineag.gr/icicth/

September 10-13, 2003
The Second Joint US and Canadian Case Mix and Quality Assurance Conference
Victoria, BC
For more information:
Karen Stefanson, Conference Coordinator
Tel: (250) 384-1266
info@casemixconference.com
www.platinumincentives.com

November 2-5, 2003
20th International Conference of the International Society for Quality in Health Care Wyndham Anatole Hotel
Dallas, TX
For more information:
isqua@isqua.org
www.isqua.org

November 30 - December 2, 2003
From Policy to Practice... The Home Care Challenge
13th Annual Canadian Home Care Association Conference
Hilton Toronto
Toronto, ON
Call for Abstracts: Deadline May 30, 2003
For more information:
www.cdnhomecare.on.ca

June 16-20, 2004
Canadian Association of Physical Medicine and Rehabilitation Medicine (CAPM&R) / RehabNet Annual Meeting
Delta Prince Edward
Charlottetown, PEI
For more information,
E-mail us: capmr@rcpsc.edu

September 3-6, 2004
3rd Congress of International Federation of Paediatric Societies and the VI Brazilian Congress of Paediatrics Orthopaedic
Bahia Othon Palace Hotel
Brazil-Salvador-Bahia
For more information:
www.ifpos2004.com.br

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Please fill in the following form, print it on your own printer, sign it and send it along with your payment by mail or fax to the above address:

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City/Province/Postal Code: ______________________________

Please check all that apply:

❒ I would like information regarding ______________________________

❒ I would like to make a donation in the amount of $ ______________________________

❒ I hereby direct that the gift noted above, made to the Canadian Physiatrists Research and Development Foundation, Registration #0909671-11, be held for a period of not less than ten years

OR

❒ I hereby direct that the gift noted above, made to the Canadian Physiatrists Research and Development Foundation, Registration #0909671-11, be used immediately for the Foundation activities and awards in the year of donation.

❒ By cheque payable to: CPRDF

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❒ Mastercard

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Date: ______________________________

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Purpose of the Canadian Physiatrists Research and Development Foundation:
To promote research and development of the specialty by physicians in the field of physical medicine and rehabilitation.

Donation to the Canadian Physiatrists Research and Development Foundation:

Lump sum donation of: **$**__________

Five year pledge of: **$**__________ **(yearly donation of this amount pledged for five consecutive years)**

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Name: ____

Signature: ____

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