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"Last trip to the beach", PEI

Congratulations to

SCOTT WIEBE

Winner of the CAMP&R

Photo Contest for the Fall 2004 Issue of the Newsletter

You want to participate and win \$50 if your photo is selected and published in the Newsletter?

Please send in your entries at capmr@rcpsc.edu

and take note of the following information:

Theme: 'Athletes with Disabilities'. Deadline is January 15, 2005.

FROM THE EDITOR

Hello again and greetings from the nation's capital, where fall colours have given way to subzero temperatures and the sounds of frost being scraped from car windshields. This is the first newsletter since our annual meeting in PEI, which I hope everyone enjoyed as much as I did.

We have some excellent submissions for this edition of the newsletter. Sue Dojeiji continues to supply us with first-rate information and guidance in the Education Corner series. I hope that everyone has been taking advantage of her expertise in this series. Thanks also to Gaëtan Tardif for his article on the Paralympic Games – I'm sure we all wish we could have been there.

I would like to draw special attention to the piece from Joy Wee and Pam Barton on "The Role of Physical Medicine & Rehabilitation in the Medical Undergraduate Curriculum within Canada". After discussing it with the authors I sent this article out for peer review, feeling that it was a topic which would resonate with many readers and might benefit from the peer review process. To my knowledge, this is the first use of peer review for this newsletter. Despite its inherent limitations (subjectivity, inconsistency of reviews, etc...) this process is currently the best one at our disposal to ensure the quality and scientific validity of medical



Jeff Blackmer, MD, MHS
(Bioethics), FRCPC

publications. While the intent of the CAPM&R newsletter has traditionally been to disseminate member news and information, perhaps it is time to give some thought to using it as a vehicle for scientific information as well.

There is currently no first-rate rehabilitation journal in Canada where members can publish their articles, and the process (and long wait) to get papers published in traditional journals has been a source of frustration for many. While I don't propose that the newsletter replace the Archives of PM&R, I would propose it as an

alternative venue. Readership of our newsletter is large and more and more academic centres are including electronic publications when deciding on such things as promotion and advancement. While the Citation Index of the CAPM&R newsletter is unlikely to approach that of even, say, the Bangladesh Journal of Cardiology, you will be reaching a target audience who will be very interested in your message and will be likely to provide you with useful feedback and suggestions.

So what say you? Is this a reasonable use of your association's newsletter? Are there others who are interested in submitting articles for peer review? Let us know your thoughts on the matter, or better yet, send us your manuscripts for review.

LE MOT DE LA RÉDACTION

Jeff Blackmer, médecin,
MHS (bioéthique), FRCPC

Me revoilà, je vous transmets mes salutations de la capitale nationale où les coloris automnaux ont cédé la place au froid mordant et au givre qui recouvre les pare-brise. Le présent bulletin d'information est le premier depuis l'assemblée annuelle à l'Île-du-Prince-Édouard, qui, j'espère, a comblé les attentes des participants autant que les miennes.

Le bulletin présente des articles captivants, comme celui de Sue Dojeiji qui continue de nous offrir de l'information hautement utile et des conseils dans sa rubrique sur l'éducation. J'espère

que les lecteurs sont nombreux à tirer parti de son expertise. Je remercie également Gaëtan Tardif de son article sur les Jeux paralympiques – nous aurions tous souhaité y être, j'en suis certain.

J'aimerais attirer votre attention sur l'article de Joy Wee et Pam Barton intitulé *The Role of Physical Medicine & Rehabilitation in the Medical Undergraduate Curriculum within Canada*. Après en avoir parlé avec les auteures, j'ai transmis l'article à des pairs examinateurs, convaincu que le sujet susciterait l'intérêt de nombreux lecteurs et que l'article bénéficierait de cet examen par des pairs. Pour autant que je sache, c'est la première fois

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PRESIDENT'S MESSAGE

Greetings from the East Coast and yes, our grass is still green!!

Let me begin by thanking Shawn Marshall and all those involved in the annual meeting in PEI. It has raised the bar for our scientific agenda and I look forward to the meeting in Ottawa in 2005.



Brenda Joyce,
MD, FRCPC

The Executive met at the annual meeting and we reviewed our financial statements and discussed fundraising. We are on track with the budget, and I trust that Stephen Vallentyne will be an excellent Treasurer. Thanks to Colleen O'Connell for all her hard work.

We approved the Education Committee's position statement on undergraduate education and will be sending this to undergraduate deans plus our own program directors.

I recently attended the newly formed Federation of National Specialty Societies of Canada AGM and topics discussed were: waitlists and times in relation to the government's new agenda; an Rx&D update; IMG certification, to name a few. I believe it is important for us to be at the table for these discussions. I will also be attending the Canadian Medical Association Committee of National Medical Organizations meeting in January.

I would like to take this opportunity to thank the Executive members who continue to contribute their knowledge and time.

MESSAGE DE LA PRÉSIDENTE

Brenda Joyce, médecin, FRCPC

Salutation de la côte Est et oui, l'automne nous a mieux traités qu'ailleurs!

En tout premier lieu, j'aimerais remercier Shawn Marshall et toutes les personnes qui ont participé à l'organisation de l'assemblée annuelle à l'Île-du-Prince-Édouard. La qualité scientifique y était irréprochable, et les organisateurs de l'assemblée qui aura lieu à Ottawa en 2005 auront fort à faire pour la surpasser.

Le Comité de direction s'est réuni à l'assemblée annuelle pour examiner les états financiers et discuter de collecte de fonds. Nous respectons le budget, et je suis convaincue que Stephen Vallentyne, nouveau trésorier, saura maintenir le cap. J'adresse mes remerciements à Colleen O'Connell qui a su bien faire les choses.

Nous avons approuvé l'exposé de principe du Comité de l'éducation quant aux études médicales

de premier cycle, que nous ferons parvenir aux doyens des études de premier cycle ainsi qu'aux directeurs de programme.

Dernièrement, j'ai participé à l'assemblée générale annuelle de la nouvelle Fédération nationale des sociétés de spécialistes du Canada où les sujets suivants ont été abordés entre autres: les listes d'attente en regard de la nouvelle priorité du gouvernement; une mise à jour de Rx&D; le certificat en médecine interne générale. Je crois fermement qu'il nous sera utile de faire entendre notre voix dans ce groupe. J'assisterai également à la réunion du Comité de l'Association médicale canadienne sur les organisations médicales nationales en janvier.

Enfin, je tiens à remercier les membres du Comité de direction qui ne ménagent ni le temps ni les efforts, et qui partagent leur savoir.

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qu'un article du bulletin d'information passe par l'examen par des pairs. Malgré ses limites inhérentes (subjectivité, manque d'uniformité, etc.), cette procédure est la seule dont nous disposons pour assurer la qualité et la validité scientifiques des communications médicales. Bien que le bulletin d'information de l'ACMP&R ait été prévu à l'origine pour transmettre des nouvelles et de l'information aux membres, le temps est peut-être venu d'envisager la possibilité d'y faire paraître de l'information scientifique également.

Il n'existe actuellement aucune revue de premier ordre sur la réadaptation au Canada, qui publie les articles des membres, et la longueur et la complexité de la présentation de communications en vue de la publication dans des revues traditionnelles en ont mécontenté plus d'un. Loin de moi l'intention de suggérer que le bulletin d'information remplace *Archives of PM&R*, je proposerais plutôt une autre option. Le lectorat du

bulletin d'information est vaste, et les établissements d'enseignement supérieur sont de plus en plus nombreux à tenir compte des publications électroniques au moment d'une promotion ou de l'avancement de carrière. Même si l'index des mots-clés renvoyant au bulletin d'information de l'ACMP&R ne sera jamais aussi étendu que celui de la Revue de cardiologie du Bangladesh par exemple, il permettrait néanmoins au bulletin de rayonner auprès d'un auditoire cible désireux de connaître votre message et d'y réagir par des observations.

Alors, qu'en dites-vous? Les lecteurs du bulletin sont-ils prêts à y trouver de l'information scientifique? Y a-t-il des auteurs qui seraient prêts à soumettre leur article à l'examen par des pairs? Faites connaître votre opinion à ce sujet, ou mieux encore, envoyez-nous des manuscrits.

Canadian Association of Physical Medicine and Rehabilitation Annual Scientific Meeting June 15-18, 2005 The Fairmont Château Laurier Ottawa, Ontario

Call for Abstracts

The next Annual Scientific Meeting will be held June 15-18, 2005 at the Fairmont Château Laurier in Ottawa, Ontario. The Call for Abstracts is posted on the CAPM&R website at <http://capmr.medical.org/agm2005.htm>.

The deadline for submissions is February 15, 2005.

Additional information regarding the 2005 Annual Scientific Meeting will be posted on our website as it becomes available. Photo highlights from the last meeting are also posted on our website.

EDUCATION CORNER

The Difficult Resident or the Resident in Difficulty

Sue Dojeiji, MD, MEd, FRCPC

Welcome back to the fall edition of Education Corner. With autumn, we turn our attention to another exciting academic year. I thought I would devote this issue to the topic of the resident in difficulty. This is a summary of the Education Special Interest Group session in June 2004. I want to thank those who attended for their active participation.

Let's look at the following cases and see if any look familiar. Think about these cases as you're going through this article. What would you do? What did you do? What would you do differently?

SCENARIO #1

Joe is a very charming and likeable PGY-2. He received a poor evaluation from his Medicine mid-rotation evaluation – “borderline” knowledge base. While he is delightful to work with, he must improve his knowledge base if he is to pass his rotation.

Two other physicians agree that Joe has a problem with knowledge, but they really like him.

SCENARIO #2

Sue is a bright PGY-1 who has excelled in her first 6 months of residency. More recently, she's been struggling with a heavy rotation (Neurology). She doesn't have time to come to teaching sessions. She doesn't appear to be checking her patient's reports. She over-investigates her patients and doesn't seem to be able to prioritize properly. She is pale and intense. The nurse on the team is concerned she is not functioning as well as she usually does.

SCENARIO #3

Tim is a PGY-5 studying for his PM&R fellowship exam. He is very friendly and outgoing. He's always enjoyed his “drink”, but lately he smells of alcohol during the day. One of the ward nurses thought she smelled alcohol on his breath in the morning and became concerned.

Ring a bell?

Of all of the activities as teachers, educators and program directors, dealing with residents in difficulty is one of the most stressful and frustrating. Sadly, very little has been published, but there are some good frameworks available to guide us. Probably the most helpful and practical is the framework developed by Yvonne Steinert in the Faculty Development Office at the McGill University. I would recommend reading her article to obtain more detail. Also, McGill offers a 2-day workshop on this topic every few years. You may wish to approach your local Faculty Development office to assist with providing you a similar workshop in your area.

The first big step is to shift our thinking from the “difficult” resident to the “resident in difficulty”. The problem may lie within the learner, but it is conceivable that there may be a systems problem (what to do in this rotation), a situational problem (temporary issue) or a teacher problem. To do our jobs well, we need to take the time to discover and uncover the sources of difficulty (there may be more than one), if we truly wish to help our learners.

I will briefly summarize the concepts from the Yvonne Steinert framework.

The steps are as follows:

1. Defining the problem

- a. Step 1: Suspecting a problem
 - i. What is the problem?
 - ii. What are the contributing factors?
 - iii. What is the potential impact of the problem?
 - iv. Is it a problem that must be changed?
- b. Step 2: Confirming initial suspicions
 - i. What is the resident's perception?
 - ii. What are the resident's perceived strengths/weaknesses?
 - iii. What is the resident's relevant life history?
 - iv. What are the teacher's perceived strengths and weaknesses?
 - v. How do other teachers perceive the resident?

2. Designing the intervention

- i. What problem are you trying to address?
- ii. How will you address the problem?

- iii. Who will be involved in the intervention?
- iv. How will the intervention be documented?
- v. How will the intervention be evaluated?

As teachers, we often suspect there is a problem. It may come informally as a “gut” feeling or from rumors around the group. Other times, the problem comes to our attention more formally with other teachers speaking with us or seeing recurrent issues arise on in-training evaluation records (ITER).

As a supervisor, the first step is to determine where the problem lies. The problem may be with the trainee, but it may also lie within the system or the teacher. System problems include but are not limited to: too much work, too little time, unclear responsibilities, unclear standards or rotation objectives, lack of appropriate supervision or guidance, difficult and demanding patients, little positive feedback, and little administrative support.

Teacher issues include: misaligned expectations and assumptions, too little time, difficulty fulfilling a teaching role, stress, reactions to challenging situations, difficulty with and avoiding confrontation, and lack of experience or feeling insecure in the knowledge base.

Resident issues usually fall in one of three categories: knowledge, skill, and attitude. Sometimes, skill and attitude problems overlap. Knowledge deficits (basic or clinical sciences) may be difficult to pinpoint at first but easier to remediate once identified.

Attitude problems are easy to identify, but we can all agree they can be difficult to resolve. Attitude problems may present as difficulties with the doctor-patient relationship, interpersonal conflict with other clinicians, residents or professionals, problems with responsibilities, and problems with self-assessment.

Skill problems may include problems with interpretation of information, performance of technical skills or organization of work.

Time and direct observation are required to truly appreciate the magnitude and the specificity of the problem. There may be more than one problem or issue to deal with.

The impact of the problem(s) is far reaching. The resident may feel stressed, overwhelmed, inadequate or insecure. There is a fear of being labeled as a problem, so in effect, the reputation becomes a self-fulfilling prophecy. Faculty response can range from denial, helplessness or the urge to rescue the resident.

Residents in the program almost always sense that there is something wrong. They may feel that one resident being singled out is arbitrary. They may fear they will be next. A toxic effect may develop with residents feeling resentment toward the resident in difficulty as all the attention is being devoted to one resident at the exclusion of all others. Finally, patient care may be impacted if the resident knowledge or skill is deficient. Immediate action is usually warranted in such cases.

Finally, the teacher needs to decide if what is observed is a true problem. Ask yourself: What would happen if this didn't change?

Once the teacher has developed a hypothesis about the problem(s), test the theory by meeting with the resident. The teacher may wish to discuss further with other faculty and perhaps the program director to gather more information. Depending on the magnitude of the problem, the program director may need to be involved at this stage to assist with facilitating the identification of the problem(s) and developing a resolution strategy.

It is best to begin with the resident's perceptions of the identified issues with specifics. What difficulties if any are perceived? What is their perception of the problem? This is the most important step. It is best done earlier than later in a rotation. If the expectation is set-up at the beginning of the rotation that regular and frequent feedback will be given, the interaction will not come as a surprise to the resident.

Reflect on and review the resident's strengths and weaknesses so it becomes a part of the process (see the Education Corner issue, Winter 2003, on how to give and receive feedback!). The discussion should review ability in knowledge, skill and attitude. Specific, first-hand information is best. Off the cuff and second hand information is useless, quite honestly, and difficult to defend.

Next, the teacher attempts to determine if there are relevant life-issues that may be impacting on the picture. Some residents may not be comfortable

with divulging personal details, but indicate specifics are not necessary. The resident may be depressed, anxious or overwhelmed by a specific life circumstance. Drugs and alcohol dependency may be an issue. This may be a recurring issue. Coping strategies may be helpful to determine as there may not be the usual resources or supports systems previously relied upon. Indicate your reasons for inquiry are to assist the resident as much as possible in coming to a valid intervention.

If personal issues are impacting performance, more patient time and a reading list is unlikely to help matters. However, directing the resident to the program director will allow access to specific resources that may be more appropriate (e.g., counseling).

As teachers, it is important to reflect on our strengths and weaknesses to see how our perceptions may be impacting the problem. At this time, you may wish to discuss with other faculty in similar and in different clinical settings. Perhaps the resident does well in inpatient based rotations, but has a problem with outpatient based rotations.

You may wish to review with the program director early on for several reasons. First, there may be further information available from other rotations, practice exams and so forth that may help to confirm your observations. The program director may assist in facilitating the interaction between the teacher and resident, in directing the resident to appropriate resources, and in establishing the remediation or probation programs.

As you may have noticed, this process takes time. However, there are occasions when immediate action is required: substance abuse and/or lack of judgment causing dangerous behaviour. Generally, early intervention with the program director and the post-graduate dean is required if patient care and resident health may be compromised.

In designing interventions, supervisors may feel they need to do this alone. Program directors and post-graduate deans are available to assist. Often problems rarely occur in isolation, so the supervisor may need to prioritize with the resident which problem will be dealt with first. There will be better resident buy-in in the process if there is consensus on the intervention between the supervisor and the resident.

Many options exist for managing problems. If you don't know, ask. The intervention will depend on

the nature of the problem. The following are example of approaches to knowledge, attitude and skill problems.

Knowledge problem:

1. There may be a learning disability - a referral to a psychologist may be needed. The difficulty may be poorly organized information making knowledge inaccessible.
2. Prescribed reading list with frequent presentations.
3. Case-based review of management strategies.
4. Mini-tutorials with one or more faculty.
5. Case discussion.
6. Chart reviews.
7. Practice exams: e.g., AAEM, AAPMR or a home-made written exam addressing specific content.

Skill problem:

1. Direct observation of history or physical exam.
2. Direct observation of a specific skill (e.g., knee exam).
3. Videotape real patient or standardized patient interactions and review with the resident (e.g., communication skills like obtaining DNR, breaking bad news).
4. Prescribed reading on communication skills and physical examination followed by practice with a volunteer.
5. Videotaped review of a specific skill – injection, knee exam.
6. Practice OSCE.
7. Review of consultation notes using a validated rating scale (it exists).

Attitude problem:

1. Psychiatric intervention in the case of depression, aggression, anxiety.
2. Counseling for time management, prioritizing tasks after explicit review of expectations.
3. Change of rotations or back to home base if the resident is overwhelmed or not coping well.
4. Change to call-schedule for a period of time.

Consider your options for who will be involved in the intervention. As previously indicated, your program director is a great resource and may be able to facilitate and oversee the intervention strategy. The supervisor is the one most likely to implement the remediation strategy. However, other

faculty may be asked to assist with direct observation, teaching sessions and so forth. A trusted senior resident may assist with mentoring the resident. Outside help may be appropriate (psychologist or psychiatrist). They may assist with determining when a resident may be well enough to start working again. The resident will need to be comfortable with the people chosen.

In establishing the intervention, timelines are needed. This is a critical feature that some teachers and educators fail to implement from the outset. The worst thing is to start the intervention and be shocked that months have gone by and no change has occurred. You are no further ahead. Indicate when you expect change to occur. If you don't know, find the expertise before you begin. Decide on scheduled meetings for progress reports.

Consequences need to be clearly stipulated. You may need a formal remediation or probation contract. Most post-graduate offices have this. It is best to check with the post-graduate office – this is something a program director can help with. You may need a legal opinion for this to assure due process. Due process encompasses the concepts of fairness of the process, accuracy of the issues, and appropriate documentation.

Evaluation criteria need to be clearly outlined. There must be a system or measure of improvement. For example, with knowledge deficit, you may decide on a reading program with frequent presentations followed by a report. Or, you may wish to include a 4 station mini-OSCE to judge how specific physical examination skills have progressed. Stipulate consequences for lack of progress. Consequences may include: a specified time of extension if progress is noted, redefinition of the problem, probation for 3-6 months or dismissal.

Establish in advance how the intervention will be documented. Document a summary of the problem(s), discussions with the resident, other faculty, and the different components of the intervention including timelines, expectations, evaluations and consequences. Assure confidentiality. Ensure residents have copies of the documentation so that they are aware of the plan. There should be no surprises as to what expectations or timelines ought to be as everything should be clearly indicated as much as possible, for the resident, similar to a contract.

Finally, remember that as teachers and educators, we are the content experts. We know when performance is below expectations. The justice system bears this out. Where we fail is in adequately diagnosing and documenting the problem, and the intervention strategy. If little documentation exists, the program director has little to proceed with at the post-graduate level.

In the end, our goal is not “to get” the resident, but to help the learner succeed in their training. Sometimes, we have to concede that the resident is not well-matched to their chosen discipline or career, as difficult as it is to come to that conclusion. However, residency is also a job and if residents cannot meet the job requirements other considerations need to occur.

At this point, I'd like you to return to our three case scenarios or reflect on one of your own. What would you do?

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CONTINUING PROFESSIONAL DEVELOPMENT COMMITTEE ANNUAL REPORT 2003-2004

1 Chair

This was Dr. Trotter's first year as chair. The term is three years.

2 Vice-chair

There is currently no vice-chair and one will hopefully be identified during the 2004 meeting.

3 Membership

Dr. Denyse Richardson – past chair	Toronto
Dr. David Berbrayer	Toronto
Dr. Tim Deutscher	Nanaimo
Dr. Pankaj Dhawan	Vancouver
Dr. Richard McMillan	St. Catharines
Dr. Sue Dojeiji	Ottawa
Dr. Gaétan Tardif	Toronto
Dr. Rodney Li Pi Shan	Saskatoon
Dr. Shawn Marshall	Ottawa

4 Terms of Reference

These were discussed and approved at the June 11, 2003 meeting. They are published on the website and will be reviewed annually.

5 Accredited Provider Status

Our provisional status as an accredited provider was to have been reviewed by the Royal College in March 2004 but has been delayed until August 27, 2004.

6 Section 1 Approvals

Seven educational events were reviewed this year for approval under Section 1 of the Maintenance of Certification Program. This included an internet on-line course offered by the OMA.

7 Accredited Continuing Professional Development Providers Conference

This was the first annual conference and was sponsored by the Royal College. Dr. Trotter attended. It was particularly helpful in its suggestions for enhancing the roles of non-Section 1 educational events, review of ethical standards for CME events, and introduction to innovative educational strategies as well as providing an excellent opportunity for networking with other accredited providers.

8 Evaluation Forms and Needs Assessment

A new evaluation form was used for the 2003 Scientific Meeting. It will be reviewed by the CPD Committee at the June 2004 meeting to make sure it meets our needs and is fully compliant with Royal College guidelines.

A new needs assessment form has been designed which will be distributed to all CAPM&R members to facilitate planning for next year's scientific meeting.

Respectfully submitted,

Judy Trotter, MD, FRCPC
Chair

EDUCATION COMMITTEE ANNUAL REPORT 2003-2004

1 Chair:

This was Dr. Dojeiji's third year as chair of the Medical Education Committee. Dr. Dojeiji will complete her tenure this year and hand-over to the oncoming chair during the meeting. The committee accepted Dr. Lalith Satkunam's nomination and approved the position of chair for 2005-2008 term.

2 Vice-chair:

No vice-chair was identified this last meeting; the Committee is looking for interested Psychiatrists.

3 Membership:

Dr. David Berbrayer	Toronto
Dr. John Latter	Calgary
Dr. Meridith Marks	Ottawa
Dr. Denyse Richardson	Toronto
Dr. Lila Rudachyk	Saskatoon
Dr. Joy Wee	Kingston
Dr. Nancy Dudek	Ottawa

Resident Representative (final year)

4 Resident Essay Contest:

There were 4 excellent resident essay contest submissions for 2004. The winning essay was written by **Dr. David Flaschner**, University of Alberta, entitled: "**Pharmacotherapy for Prophylaxis of Neurogenic Heterotopic Ossification**". Each author received written feedback from 4 resident essay reviewers. The committee wishes to formally recognize the resident reviewers' hard work in assessing these essays. Committee members wondered about the decrease in essay submissions this year compared to last year (10 essays). Committee members will continue to observe. Adequate notification usually occurs through CAPM&R.

5 Student Essay Content:

We had 3 excellent submissions for the student essay contest in 2004. The winning essay was written by **Ms. Anne Conlin**, University of Western Ontario, entitled "**Chronic Low Back Pain: A Review of Evidence-Based Approaches to Treatment**". Each author received written feedback from 4 student essay reviewers. The committee wishes to formally recognize the student reviewers' hard work in assessing these essays.

6 Visiting Professorship Program:

We received one request from Dr. Rodney Li Pi Shan. His application was approved for \$1000.

7 Psychiatric Principles Education in Undergraduate Curriculum:

This continues to be a major priority of the Committee. Dr. Joy Wee and Dr. Pam Barton collaborated on a manuscript for Enhancing PM&R in Canadian Undergraduate Programs. Using this manuscript as the framework, Dr. Dojeiji and Dr. Wee created a position statement entitled "A Rationale for Teaching Psychiatric Principles in Medical School". They used feedback solicited from the Education Committee and membership at-large through Education Corner.

The Committee reviewed the position statement. The final draft was sent to the Executive for review at the annual meeting. Feedback was provided by Dr. Joyce. Once the changes are made, the Undergraduate subcommittee would like to prepare the document for the CAPM&R website and send to the medical school undergraduate deans and PM&R undergraduate coordinators by September 2004.

8 2004 Education SIG:

Dr. Dojeiji facilitated the Medical Education SIG for the 2004 CAPM&R meeting. Needs assessment showed interest in addressing issues related to the "problem resident". No specific topic was identified from this year's needs assessment. Drs. Dojeiji and Satkunam will follow-up with SIG attendees to explore further.

9 Education Corner:

Dr. Dojeiji continues to contribute to the CAPM&R newsletter column "Education Corner".

This report was updated following the annual meeting June 2004.

Respectfully submitted,

Sue Dojeiji MD MEd FRCPC
Chair – CAPM&R Education Committee

RESEARCH COMMITTEE REPORT

The third Best Poster Awards competition was held at the Annual Scientific Meeting in Charlottetown. After discussions with the Executive and members who attended previous meetings, we made changes to the format of the competition. Out of 19 submissions, 8 were selected for podium presentation. To reflect the new format, the competition was renamed 'the Best Podium Presentation Awards'. Judging from response of the meeting participants, the presentations were well received.

WINNERS OF THE COMPETITION WERE:

1st place:

Christine Yang, Saskatoon, SK. Cannabinoid inhibition of axonal injury induced by peroxyntirite

2nd place:

Guy Trudel, Ottawa, ON. Surface irregularity, sensitive methods to detect early cartilage degeneration

3rd place:

Rob Burnham, Lacombe, AB. A prospective outcome study on the effects of radiofrequency neurotomy for patients with chronic spine pain of facet joint origin.

A new research initiative launched this year was the Paper of the Year Award. It went to Guy Trudel for his paper: Measurement of articular cartilage

surface irregularity in rat knee contracture. *J Rheumatol.* 2003 Oct;30(10):2218-25. Dr. Trudel gave a nice presentation that not only covered material in the paper, but also gave insights into the journal review and publication process as well.

The Resident Research Contest winner was Nancy Dudek from the University of Ottawa for her study entitled: Dermatological conditions associated with use of a lower extremity prosthesis. The Student Research Contest winner was Anne Conlin from the University of Western Ontario. Her project was entitled: Treatment of whiplash-associated disorders: a meta-analysis and systematic review. The authors and their supervisors are to be congratulated for the high quality of their work.

The initiative on updating the CAPM&R member publication list was well received. This was made possible through the generous time and effort put in by Robert Teasell and his colleagues at the University of Western Ontario. This helps to raise the profile of research in our field. Initially, there was some confusion concerning timing of the update. At the recent Research Committee meeting, we agreed that this will be done around January/February each year for papers published during the preceding year. This coincides with the time for filing of annual reports at most universities. However, to ensure that the publication list is complete for 2002 and 2003, we are soliciting updates from members for their publications during those two years.

Report respectfully submitted by K. Ming Chan, Chair.

CAPM&R News – Guidelines for Submissions

Submissions: Please submit articles by e-mail at capmr@rcpsc.edu. All submissions are subject to editing for style, clarity and space considerations. The CAPM&R editorial staff, where appropriate, will arrange translation into the second language.

Soumissions: Veuillez soumettre vos articles par courriel à capmr@rcpsc.edu. Les documents soumis seront révisés par le rédacteur afin de maintenir style et clarté, tout en tenant compte de la longueur du document.

The Role of Physical Medicine & Rehabilitation in the Medical Undergraduate Curriculum within Canada

Wee, Joy, BSc (Hons), MD, FRCPC and Barton, Pamela M, BSc (Hons), MD, FRCPC

INTRODUCTION

Does medical undergraduate education benefit maximally from the specific and unique expertise of physiatrists? The practice of these specialists in Physical Medicine & Rehabilitation (PM&R) involves the full spectrum of the care of persons with impairments causing disability. In the context of increasing demands from society that physicians practice in interdisciplinary teams, be community based, have a holistic approach, be competent in the management of complex and persistent disease states in an aging population, and be accountable for outcomes¹⁻³, physiatrists should have much to offer in educating the undergraduate medical student.

Physiatrists are skilled in the seamless care of individuals who have incurred significant disability, as provision of care often begins in the intensive or acute care settings, progresses through intensive in- or outpatient rehabilitation phases, and follows individuals into community settings as they regain maximal independence in society.

In order to achieve these care patterns, physiatrists must be skilled in clinical examination, basic medical care, recognition of and minimizing potential medical complications, functional assessment for disability and creative problem solving to optimize function, across a spectrum of complex disabilities and disease processes in different care settings. Physiatrists' expertise in diagnosing and managing a range of neurological and musculoskeletal conditions is an asset in undergraduate medical education.

Physiatrists usually take a leadership role in creating and nurturing the growth of interdisciplinary teams and programs through which the necessary services are delivered to their disabled constituency. They develop practical expertise in leadership skills required for fostering successful interdisciplinary teams, and patient-focused health planning processes.

In a time when health care must be accountable for outcomes, physiatrists have a long history of team-based functional outcomes measurement, using instruments such as the Functional Independence Measure (FIM)⁴, that facilitate team based patient care.

The Liaison Committee on Medical Education (United States and Canada) recommends that 'rehabilitative care' be included in medical curricula⁵. In the context of the CanMEDS 2000⁶ roles of: medical expert, communicator, collaborator, manager, health advocate, scholar, professional - the field of physical medicine and rehabilitation offers excellent and possibly unique opportunities to develop the roles of communicator and collaborator, because so much of patient care occurs through the involvement of interdisciplinary teams, with extensive use of structured team rounds and patient care conferences. In addition, physiatrists are constantly modeling the roles of manager and health advocate in the daily care of their patient constituents.

How much are physiatrists involved in the teaching of undergraduate medical students? Two independent Canadian national surveys were completed fifteen years apart, each by one of the above authors (P. Barton - 1986, J. Wee - 2001) each of whom sat on the Canadian Association of Physical Medicine and Rehabilitation Education Committee at the time of their survey. The surveys were conducted with the intention of better understanding the exposure of undergraduate medical students to the field of Physical Medicine and Rehabilitation, through physiatry involvement in their education. In addition, the 2001 survey wished to determine if the development of national guidelines for medical education in the field of physiatry would be supported. Neither was aware of the other survey until 2002; thus the surveys did not follow identical formats, and there exist limitations in the ability to compare results.

METHODS

In 1986, thirteen Canadian medical schools in which psychiatrists participated in undergraduate education were requested to complete a survey form summarizing the number of psychiatrists available for teaching as well as the nature and quantity of teaching they conducted in the undergraduate medical curriculum. PM&R department heads or directors of undergraduate education were personally interviewed to ensure that data was correct. The 13 medical schools surveyed were: University of British Columbia, University of Alberta, University of Calgary, University of Saskatchewan, University of Manitoba, University of Western Ontario, Queen's University, University of Ottawa, McMaster University, University of Toronto, University of Montreal, Dalhousie University, and Memorial University.

In the 2001 survey, the focus was primarily to gauge support for the development of national guidelines for undergraduate medical education provided by psychiatry; therefore, undergraduate program directors in PM&R of Canadian medical schools that had residency training programs in PM&R, either formerly or currently, were sent surveys to complete. Two medical schools (Memorial University and the University of Calgary) had not developed PM&R residency training programs at the time, and were not sent surveys, as it was unclear who was most responsible for organizing psychiatrist teaching of medical students at these centres. Nine of 11 surveys were returned.

RESULTS

A) Number of Psychiatrists

Table 1 summarizes the total number of psychiatrists actively participating in Canadian undergraduate medical teaching programs, in 1986 and 2001. Schools are numbered rather than named. Two of the 9 returned surveys in 2001 did not include this information. In 2001, all except two schools had five or fewer full-time academic psychiatrists.

Medical School	1986		2001		
	Total # Psychiatrists	# GFTs*	Total # Psychiatrists	# Psychiatrists who taught	# GFTs*
1	14	1	18	16	1
2	6	1	NR	1	1
3	5	5	5	5	2
4	26	15	30	10-15	10
5	5	5	5	5	5
6	6	5	15	12-14	10
7	6	1	8	8	5
Total (7 schools)	68	33	>82	57-64	34
8	7	6	NR	NR	NR
9	10	9	NR	NR	NR
10	3	3	NS	NS	NS
11	7	4	NR	NR	NR
12	13	1	NR	NR	NR
13	1	0	NS	NS	NS
All 13 schools	109	56			

NR – no response given

*GFTs designates full time positions, or geographic full time

NS – not surveyed where applicable

These data reflect only the responses given on the surveys and may not in fact be totally representative of numbers of psychiatrists practicing/teaching in each centre at the time of the surveys.

B) Course Topics, Activities

Course names, topics, and other activities that physiatrists have been involved in are outlined in Tables 2 and 3.

Medicine and Society
Applied Anatomy
Neurophysiology
Interviewing Skills
Physical Examination <ul style="list-style-type: none"> • musculoskeletal • general
Functional Assessment
Long Term Disability
Rehabilitation Medicine
Major Disability/Rehabilitation <ul style="list-style-type: none"> • Amputee • Low Back Pain/ Pain • Cardiac
Electrodiagnosis

Activity	No. of Universities Participating	
	1986 (13 universities)	2001 (9 universities)
Seminars/Lectures	10	8
Clinical Skills/ Bedside Teaching	10	8
Problem Based Learning/Tutorials	7	4
Elective/Selective Rotations	13	9
Mandatory Clerkship	2	2
Summer Research Position	NS	2
Career Night	NS	2
Ambulatory Physiatry Clinics	NS	4

NS – not surveyed.

C) Hours of Teaching

In the 1986 survey, hours of PM&R related didactic lectures encountered by a medical student throughout their entire undergraduate program ranged from 0 to 17 hours, and averaged 4.4 hours. It was difficult to assess forms of teaching encounter other than lectures (eg. tutorials, problem-based learning and clinical skills) as these were usually shared with other specialties. Hours of teaching by physiatrists were not specifically requested in the 2001 survey, but were included in several responses.

It would appear that from 1986 to 2001, medical student teaching involvement by physiatrists did not appear to have changed noticeably. In some settings, hours may have increased by up to 8 hours, while in others, hours decreased.

D) Students Entering PM&R Residency

The 1986 survey found that during the 5 prior years from July 1980 to June 1985, a total of 41 medical students from 11 of the 13 universities (2 universities did not know) entered residencies in Physical Medicine and Rehabilitation.

E) National Guidelines for PM&R in Undergraduate Medical Education

The 2001 survey indicates that all responding undergraduate program directors would support the development of PM&R specialty guidelines for the undergraduate medical education curriculum in Canada. Early exposure of medical students to the field of PM&R in their core program seems to be a desired sentiment.

DISCUSSION

Educational objectives in Physical Medicine & Rehabilitation for the medical school graduate were published in the United States in 1985⁷, and the value of incorporating PM&R concepts into medical undergraduate education has been recognized⁸. Physiatrists are important sources of expertise in such instruction. The particular diagnostic and management skills exemplified by physiatrists in their management of patients with both long-term and complex disabilities, often in the context of significant disease processes, are increasingly in demand as Canada's population ages. In addition, most physiatrists are adept at the management of common musculoskeletal disorders (e.g. low back pain, neck pain, soft

tissue disorders). The average family physician is more likely to face these challenges in their daily practice than those of the acute life threatening events of the emergency room.

In more recent years, there seems to be wide agreement that rehabilitative care be taught in medical schools⁹, and that steps should be taken to: 1) examine the curricula of medical schools in their ability to achieve this objective, 2) include examination items related to rehabilitative care, 3) weave into basic science and problem based cases the impact of disease on patients' activities and participation in society, 4) involve physiatrists and other specialists in the development and dissemination of information regarding the rehabilitative care of patients. Though physiatrists have long participated in medical undergraduate education, there continues to remain a desire and potential for more contribution within the medical school curriculum. In Canada, we would encourage that physiatrists become more involved in, and use these published recommendations, to guide medical curriculum planning.

This paper has outlined the involvement of physiatrists in the medical undergraduate education curriculum in Canada over a fifteen year time span. There is a general desire expressed by physiatrists for more opportunity to be involved in undergraduate teaching, particularly early during the core training. As the specialty of PM&R moves forward in its establishment of guidelines for inclusion of rehabilitative care in undergraduate medical education curricula, it is hoped that if developed, these guidelines will be embraced by Canadian medical schools as an opportunity to move forward in the search for excellence.

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Contributors: This article was conceived, researched, developed and written jointly by both authors.

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and the University of Western Ontario Department of PM&R.

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Reflections on the Athens Paralympic Games

Gaétan Tardif, MD, FRCPC



I write this on my second day back in the office after three weeks away as a member of our 2004 Canadian Paralympic team. I hope you caught some of the coverage, the best ever for our Paralympians both on television and in print. In my last article, I wrote that this being my third trip to Paralympic, the feeling would be a bit different but it really wasn't. Sure the adrenalin rush upon entering the stadium during the opening ceremonies wasn't quite as high, but the sense of wonder was just the same if not heightened.

Being Canadian gives you a very good feeling at these international events – notwithstanding the fact we felt we were wearing pyjamas when other

countries wore jacket and tie (Roots missed the mark this year)! In a way, the clothing did fit with the Canadian image of being casual and might I say quietly bold and disruptive? I know it sounds like a total oxymoron, but any time I have been at international games the Canadian contingent has received a significant ovation and has been a fabulous guest to anyone's party – having a lot of fun and often getting the party going, but never smashing the furniture!

I know for a fact that television did not show that one of our athletes rushed to the track during opening ceremonies as the Greek delegation was passing by, gave the lady who led the Greek

delegation a small Canadian flag and a polite kiss – ensuring a good roar in the crowd and an extra turn on the track for our maple leaf! It was also our wheelchair athletes that led the way to meet the dance troupe after the show, to the total despair of the security crew, and the delight of the other wheelies who rushed the area and had their picture taken at this special moment. You just wouldn't see this at the Olympics with all that security (including the Patriot missile arrays that were still within sight of the village) but everyone feels pretty safe at the Paralympics.

As for the medical clinic, the staff was great, and many of us had done this enough times before to make do with whatever we had (or didn't have). My first job was to duct tape extension cords from the adjacent apartments since someone along the way had forgotten to wire power outlets in our basement clinic making it a bit dark and, shall we say, limiting in terms of therapy provision? Some of our supplies didn't quite make it so our dressing choices were limited to Tegaderm and op-site. As usual, we ran out of cold remedies. Viral infections are almost always the first cause of consultation to the doctors. It's a true primary care clinic where you have to remember basic care for everything from skin rashes to urethral discharges. I even got to start my first IV in probably 10 years for a dehydrated athlete with a bad GI bug who kept competing anyway. And more importantly, I did not freak out when a visually impaired athlete told me about his failing corneal transplant requiring a bit of attention. I can still feel my heart racing when that happened at the Sydney Paralympics.

I have not talked much yet about psychiatry, because in this context psychiatric knowledge, albeit very helpful in understanding the patient's symptoms, takes second place to being a solid all around doctor. "Seasoned" psychiatrists like me learned to medically run a rehab unit on our own, thus acquiring practical primary care skills. I am however worried that nowadays, a majority of psychiatry trainees are not being exposed to enough primary care to develop these skills. It would be a real shame, and detrimental to the Paralympic athletes, if it came to psychiatry being excluded from this type of games experience because of a gap in skills set. I'm not advocating a return to the old internship, but I would suggest to all our residents that gently letting the rehabilitation unit attending GP know you want to be in charge under their supervision would go a long way in developing these

skills. After starting IVs, dispensing or injecting meds, changing dressings and helping injured athletes transfer during the trip, I even caught one athlete jokingly referring to me a "nurse Gaétan" which I did not mind one bit. After all, any of us was ready and willing to do whatever was needed to provide our athletes with the best chance to succeed at these games.

I will remember many of these athletes for their dedication to their sport, their stories of how they got there in the first place, their appreciation for the help we were able to provide, and their friendliness under high stress circumstances. I truly enjoyed seeing again some of the youngsters I first met in Sydney, seeing how they evolved and matured and how they redefine success on a regular basis in their lives. Most of all, I will remember the camaraderie in a medical team composed of people from different backgrounds and different regions going through all the stages of team formation and functioning at warp speed, making the games experience the best school for quick adaptation ever devised.

Sandy Pinkerton Quaich

The 2004 Sandy Pinkerton Quaich was a tremendous success. The winner of the Quaich was Steve Bagg. Other winners include:

Low Female: Fionnuala Killian
Low Gross: Tom Miller
Most Honest: Joanne Sequeira
Longest Drive Male: Steve Bagg
Longest Drive Female: Fionnuala Killian

Please read Tom Miller's report on this year's Quaich for more details:
http://capmr.medical.org/sandy_pinkerton_quaich.pdf

What is Performance Arts Medicine?

Dr. Joy Wee, Physiatrist

CASE

A 38-year-old semi-professional guitarist has tingling in left 3rd and 4th digits, without numbness. Some elbow discomfort is reported. Neck stiffness is present especially when times are stressful. He is not aware of any ongoing medical conditions but smokes and consumes alcohol regularly. There has been no change in activities of daily living. His performance schedule remains the same: two or three performances weekly, with 30 minute breaks between sets. There may be up to two weeks between performances. He changed his guitar two years previously, and feels more comfortable.

Question: What kinds of conditions should be considered?

PERFORMANCE ARTS MEDICINE

This branch of medicine deals with occupational difficulties of musicians and dancers, related to their performance demands. Conditions such as overuse, nerve entrapments, tendonitis, and muscular complaints are frequent. These could be due to a combination of posture, instrumental ergonomics, and/or practice scheduling.

In order to appropriately assess and assist instrumentalists, the specialist in performance arts medicine completes a medical assessment of the musician that includes the musician demonstrating how he or she plays his/her instrument. The specialist must also be familiar with the culture of musicians and dancers, and the stresses they face. Few physicians specialize in this branch of medicine. Some physiatrists have an interest in performance arts medicine. In Ontario, there are physiatrist-run clinics in Kingston (St. Mary's of the Lake Hospital), Hamilton (Musicians' Clinic of Canada), and London (St. Joseph's Hospital-Musicians' Clinic), in which performing artists are evaluated and assisted in maximizing their occupational abilities.

Other like-minded health professionals such as occupational therapists, physiotherapists, kinesiologists, and speech pathologists, work with performance artists to manage identified conditions.

For vocalists, there are voice clinics specifically designed to assess vocal cord and oral structures, and manage vocalization dysfunction. These clinics are generally run by otolaryngologists, in conjunction with speech pathologists.

In order to appropriately assess and assist instrumentalists, the specialist in performance arts medicine completes a medical assessment of the musician that includes the musician demonstrating how he or she plays his/her instrument.

Performing artists are a specialized group of people. A more recognized parallel in medicine is sports medicine, which serves elite athletes. However, performing artists have their own unique challenges, and generally require a different approach than athletes. Surgical management is often avoided, and prolonged rest from aggravating activities is unlikely, especially in professionals.

CASE WRAP-UP

After examining the patient play his guitar, it was determined that there were no trigger points or dystonic posturing. However, there was significant flexion of the wrist when playing in the lower registers, especially in standing compared with sitting. Nerve conduction studies revealed mild carpal tunnel syndrome. Efforts would lie in altering technique during instrumental playing, along with the usual means of managing mild carpal tunnel syndrome.

Dr. Wee is an assistant professor at Queen's University and sees performance artists in her practice at Providence Continuing Care Centre, St. Mary's of the Lake Hospital Site, Kingston, Ontario.

2004 CONTEST WINNERS

DR. DAVID FLASCHNER – WINNER OF THE 2004 RESIDENT ESSAY CONTEST

PHARMACOTHERAPY FOR PROPHYLAXIS OF NEUROGENIC HETEROTOPIC OSSIFICATION

*David Mark Flaschner,
Edmonton, AB*

Neurogenic heterotopic ossification (NHO) is a relatively common complication of central nervous system (CNS) injury. This article examines the current evidence for prophylaxis of NHO following CNS injury.



Methods: A thorough review of all available electronic databases as well as a bibliographic survey of all relevant articles was undertaken. The authors of pertinent articles were also contacted for additional unpublished data. Articles were described and critically appraised.

Results: Evidence for indomethacin, etidronate and warfarin exists. Of 384 articles, five were identified which address the prophylaxis of NHO prior to identifiable findings on radiographic studies. The literature is however of limited methodological quality.

Conclusions: There is data to support the efficacy of prophylaxis of NHO but it currently does not meet the expected standards for evidence-based systematic reviews. Regional practice guidelines will define practice patterns and further investigation is required to ensure efficacy and safety prior to adopting more definitive recommendations.

DR. NANCY DUDEK – WINNER OF THE 2004 RESIDENT RESEARCH CONTEST

DERMATOLOGIC CONDITIONS ASSOCIATED WITH USE OF A LOWER EXTREMITY PROSTHESIS

*NL Dudek, MB Marks, SC
Marshall, JPW Chardon*

Objectives: The objectives of this study were to: 1) document the frequency of skin problems among lower limb prosthetic users and 2) assess for factors associated with skin problems among patients using a prosthesis.

Methods: A six-year retrospective chart review using physician clinic notes of all lower extremity prosthetic users who were assessed in the outpatient amputee clinic at The Rehabilitation Centre in Ottawa, Canada was performed. Information was collected about the amputee, their prosthesis and the presence or absence of any skin problems. Descriptive and non-parametric statistics were used to analyze data.

Results: Seven hundred and forty five subjects with a total of 828 lower extremity amputations were included. Three hundred and thirty seven (40.7%) residual limbs had at least one skin problem. Adjusted odds ratios demonstrated that amputation level, being employed, type of walking aid and absence of peripheral vascular disease (as a co-morbidity) were independently associated with the presence of at least one skin problem ($p < 0.05$).

Conclusions: Dermatological conditions are a frequent complication for the lower extremity amputee who uses a prosthesis. The results suggest that more active amputees have an increased risk for developing skin problems. Further study in this area is warranted.



MS. ANNE CONLIN – WINNER OF THE 2004 MEDICAL STUDENT ESSAY CONTEST

CHRONIC LOW BACK PAIN: A REVIEW OF EVIDENCE-BASED APPROACHES TO TREATMENT

Anne Conlin
Year III
Doctor of Medicine
Program
University of Western
Ontario



Low back pain is one of the most common problems a healthcare provider will encounter. Moreover, low back pain is often a chronic condition and presents considerable direct and indirect costs to society. A multitude of healthcare providers treat low back pain in a variety of different ways. The Cochrane Collaboration has completed systematic reviews on treatment modalities employed through allopathic medicine interventions, complementary medicine interventions, and multidisciplinary interventions. In six of the eight reviews published by the Cochrane Collaboration on chronic low back pain, the authors state that the number of high quality randomized controlled trials was insufficient for the reviewers to draw conclusions. However, massage therapy was deemed effective at least one year after treatment. Bio-psycho-social rehabilitation programs of at least 100 hours duration are also effective. The importance of conducting large, well-designed trials to determine the utility of other interventions for low back pain is stressed.

MS. ANNE CONLIN – WINNER OF THE 2004 STUDENT RESEARCH CONTEST

TREATMENT OF WHIPLASH-ASSOCIATED DISORDERS: A META-ANALYSIS AND SYSTEMATIC REVIEW

Anne Conlin, BA&Sc
Sanjit Bhogal, BA
Keith Sequeira, MD, FRCPC
Robert Teasell, MD, FRCPC
Department of Physical Medicine and Rehabilitation
St. Joseph's Health Centre – Parkwood Hospital,
London, Ontario, Canada

Background: Whiplash-associated disorder (WAD) is a term used to describe injury due to an acceleration-deceleration mechanism about the neck. WAD represents a very common and costly condition. In 1995, the Quebec Task Force published a report that contained evidence-based recommendations regarding the treatment of WAD based on studies completed prior to 1993, as well as consensus-based recommendations.

Objective: To provide a meta-analysis and systematic review of the literature published between January 1993 and July 2003 on interventions for WAD.

Methods of the Review: Randomized controlled trials (RCT) and epidemiological studies were categorized by treatment modality and analyzed by outcome measure. Methodological quality of the RCTs was assessed. When possible, pooled analyses of the RCTs were completed for meta-analyses of the data. Results of all studies were compiled and systematically reviewed.

Results: Studies were categorized into activation-based, medical-based, and surgical-based interventions. A total of 15 RCTs were evaluated, including one of poor methodological quality. Pooled analyses were completed across all treatment modalities and outcome measures. Strong evidence supported mobilization for acute WAD and radiofrequency neurotomy for chronic WAD.

Conclusions: Important RCTs and epidemiological studies have been published since 1993. Implications for clinical practice and research are discussed.

Canadian Association of Physical Medicine and Rehabilitation
ANNUAL SCIENTIFIC MEETING
June 15-18, 2005
The Fairmont Château Laurier
Ottawa, Ontario

CALL FOR WORKSHOPS

The purpose of the workshops is to provide a forum for conference attendees to acquire knowledge and skills in accordance with the essential roles of physicians as identified through the CanMEDS 2000 project. These roles represent physician as: medical expert/clinical decision-maker, communicator, collaborator, manager, health advocate, scholar and professional. The workshop topic areas have been identified by a needs analysis of the CAPM&R completed in 2004.

A half-day of the meeting will be devoted to concurrent workshops. Based on the success of the peer reviewed sessions in 2004, we are seeking proposals for workshops for the 2005 Annual Scientific Meeting. Due to the joint session with the Canadian Congress of Neurological Sciences on Friday afternoon, the workshops will take place on Saturday afternoon. The 1.5 hour sessions will provide focused interactive learning experiences for the participants. Workshop presenters may be asked to present one or two sessions. Methods must allow for active participation of the participants. Workshops are not intended to be interactive group discussions nor seminars.

Topic Areas for Workshops (Based on Needs Analysis 2004):

1. Musculoskeletal Physical Examination
2. Teaching Skills
3. Team Functioning
4. Knowledge Translation

Selection Process:

- Workshop abstracts will be peer-reviewed and selected based on:
- Relevance to the identified topic areas
 - Clarity of abstract
 - Appropriateness as a workshop

Submission Requirements:

- A cover letter and 300-word abstract (see attached guidelines)
- Submit to the CAPM&R office:
E-mail: capmr@rcpsc.edu or Fax: 613-730-1116

Submission Deadline: January 7, 2005

Call for Workshops – Submission Guidelines

1. A cover letter outlining:

- The corresponding author with contact information
- Number of times willing to offer the workshop – once or twice
- Number of participants preferred in the workshop (Maximum of 25)
- Equipment and audio-visual needs

2. Abstract requirements

Title: Should reflect the purpose of the workshop.

Facilitators: List all presenters participating in the workshop.

Intended audience: Who specifically would be interested in attending this workshop?

Rationale: Which of the identified topic areas does this workshop address?

Objectives: Indicate what the participants will achieve by participating in the workshop, by completing the following statement.

By the end of this workshop, participants will be able to:

- 1.
- 2.
- 3.

Format/methods: Identify specific teaching methods to be used during the workshop. Include a timeline for the 90 minutes of the workshop.

3. Submission

Submit by January 7, 2005 to the CAPM&R office

E-mail: capmr@rcpsc.edu or Fax: 613-730-1116