BY DAN CHANG

5 THINGS I WISH I KNEW BEFORE STARTING PRIVATE PRACTICE

THE FLEXING PHYSIO

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MEET YOUR AUTHOR

My name's Dan Chang. I was born in Taiwan in 1997 and when I was one years old, my family decided to immigrate to New Zealand which is where I grew up. When I left high school, I flew straight to the beautiful city of Newcastle to pursue Physiotherapy. In my final year of Physio school, I did the year-long placement in Tamworth alongside with 8 other legends and I ended up getting a private practice gig in Tamworth at Pro-Active Physiotherapy. I spent 3 years working there, before my wife and I decided to move to Melbourne in 2022. I love my job and I love helping students and New Grads find their way in the complex life of a Physiotherapist.

Let's get this bread!

My Purpose

Boom Shakalaka, just like that, you've graduated Uni and now you're a qualified Physiotherapist. Because you're proactive and a super high achiever since being out of the womb, you secured yourself your "dream" private practice job months before even graduating uni.

You rock up on your first day of work with a bright smile, a nice fitting polo shirt, some professional chino work pants, some RM Williams boots and most importantly, the expectation to fix all your patients.

You approach the waiting room to collect your FIRST. EVER. REAL. PATIENT.

You're heart is pounding, your palms are sweaty, the adrenaline is rushing through your veins.

My Purpose

You call out the name, “Michael?”.

And from the back of the room, a middle-aged man looks at you with the dirtiest of looks and grumbles, “here we F%#KING go...” as he attempts to get up from his chair. A look of anguish drips over his face as he clenches his lower back in agony and hobbles towards you. The smell of cigarettes and stale sweat puncture your nostrils as you are shocked from his presentation. All your physio content from the 4 years of uni seem to seep from your brain alongside with your once bright and warm smile...

This was my story from my first day ever.... in PRIVATE PRACTICE.

My Purpose

WHAT'S UP LEGEND, thank you so much for downloading my eBook. My name's Dan Chang and I'm a Physio who graduated from The University of Newcastle in 2019. This eBook contains the top 5 key concepts I wish someone had explained to me before I started my career in private practice.

The purpose of this eBook is to provide NO BS and REAL LIFE advice for YOU who are already or seriously thinking about working in a private practice. So YOU are at least prepared to face the joys and woes of what private prac can bring.

I really do hope you learn a thing or two from this.

Happy reading and rehabbing,

The Flexing Physio aka Uncle Dan <3

Chapter 1 - HOW TO CONSTRUCT A BOMB CONSULT

Alrighty fam, so from Uni, you should already be a subjective interviewing King/Queen. You've done countless interviews on placement. You know what to ask. Everything including their CHx, PMHx, Aggs/Eases, 24hr pattern, Red flags, SHx, Gen Health, Meds blah blah blah. You know all these questions like the back of your hand.

BUT...

What do you do when they answer 5 of the above things plus telling you their father has Parkinson's disease plus they have 10 cats at home, when you've only asked them, "HOW ARE YOU?" This is the art of the SUBJECTIVE INTERVIEW, and it comes with loads of practice. From time and repetition, you will learn to flesh out the relevant information from the random BS you can utilise for banter later.

From my podcast, you would have heard me say numerous times that, "a GOOD subjective interview will tell you what the DIAGNOSIS is, and the objective assessment is to either confirm or deny your diagnosis"... and this couldn't be TRUER.

Now, when I first started in private practice at Pro-Active Physiotherapy in Tamworth, I had 60 minutes for my initials and 45 minutes for my follow ups. Can I just say, this was PLENTY of time and I cannot recommend enough the importance of having PLENTY of time when you first start out. When you are already nervous and stressed about treating patients with no direct supervision, you are bound to forget things, and that's OK! So having lots of time to be thorough is vital. If the private practice you end up working in wants their new grads to finish an initial appointment in 30 minutes or less, GET DA HELL OUTTA there.

They generally don't value their new grad's mental health and offer little support as they view them as money making trees.

So when you first get the patient into your treatment room, don't be afraid to take the first couple of minutes to have a chin wag and spin a big ol' yarn with them, instead of bum rushing them and hitting them with "SO, HOW CAN I HELP YOU?" or "WHAT BRINGS YOU IN TO SEE ME TODAY?" If the patient is in obvious signs of distress and anguish, probably don't begin with "Gee whizz, did you catch the footy on the weekend?" In this case, I would want to get them as comfortable as I can whether it be standing, sitting, supine or prone, and then I would get into the interview ASAP.

So... use your clinical judgement for this one.

Now, one thing you will come to realise is that in real life, the subjective, objective and treatment very much blends together. It's not like the Uni placement days where it was...

BOOM! Subjective.

And then BOOM! Objective.

And then BOOM! You're in the TREATMENT zone, Baby!

Your objective assessment essentially begins when you collect them from the waiting room. Watch carefully (without looking like a perv), how they stand up from their chair and walk towards you. Their 'functional sit to stand' and 'gait' analysis has already begun, Baby!!

Anyways, once you have finished the 'formal' part of your subjective interview, I generally say to them "Alright, let's get you up and have a look at how you move!"

Now, between the subjective and objective interview, there is NO SHAME in leaving the room to gather your thoughts and think through what your top differential diagnosis are and what objective tests you want to perform.

***quick story time... when I was at Pro-Active, my colleague by the name of Bri Short would come into my office during the day, unannounced and I would say "OH hey Bri" and she'd say "Shush, I'm here to think!". If Bri does this, then you can too! OK, end of story*.**

My advice when it comes to doing the objective examination is always start with the basics and less provocative ones. Usually it's AROM then PROM (I like doing PROM in supine, where the patient is most relaxed... hopefully). Now, your skill matters here. If you are shaky and unconfident with how you do these tests, your patient will literally feel you shaking, so the key here is to... PRACTICE lots.

There's no simple way around it. Practice on the more experienced work colleagues and get direct advice from them is your best bet. Once I get my online seminar and face to face course running, sign up to learn more. *shameless self plug*.

quick clinical pearl... when assessing the knee MCL for example, literally get in there and have the patient's foot resting on your hip and their shin tucked under your armpit and both your hands on either side of their knee joint. The more physical contact YOU have with the patient (in an appropriate way, of course.. you creep) the more sense of CONTROL and CALMNESS, your patient will have, and therefore relax more, so you can get a better assessment and less false negatives. The same goes for doing the Lachman's anterior draw test for the ACL. If their hammy's are switched on like donkey kong, you are likely going to get a false negative test. Something you can do is spin a FAT yarn to them while actually assessing their body part. The art of distraction is truly magical.

So from your subjective interview and now objective interview, you should hopefully have a pretty good idea of what's causing their pain. OR you could have no freakin' clue and hey, that happens from time to time and that's OK!! Therefore, working in a supportive clinic is CRUCIAL. When you run into a mental brick wall, you NEED to have other seasoned professionals to bounce ideas off. Maybe you forgot to ask an important question, maybe you didn't consider that it could be referral from another joint. This is what makes PHYSIOTHERAPY so much fun. It's not always Michael Jackson Black and White. We thrive in the grey zone, BOYY!!

This rolls us into the "treatment" part of the consult, which could include anything from education, manual therapy, exercise therapy, cupping or dry needling. As PHYSIOS, we have a big toolbelt with many methods to A) modify a patient's symptoms and B) prescribe exercises to build a stronger body.

I'm not Adam Meakins, so I won't say you are wrong for doing one treatment over the other, but at the end of the day, if the patient leaves my room feeling empowered to try build a resilient body and not become dependent on me for pain relief, then I can sleep like a baby at night.

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Now, you've been sitting down for too long... go make yourself a cuppa. In the next few chapters, we are going to explore what the BEST exercises to prescribe to your patients are

Stay tuned.

Chapter 2 - HOW TO PRESCRIBE THE BEST EXERCISES

Well done! You've made it this far and now getting to the juicy, meat (unless vegan of course) and potatoes "EXERCISE PRESCRIPTION" part of the consult. You should at this stage still have 15-20 minutes to go with your consult time.

When I first started private practice, I would prescribe 5-7 exercises and write it all out on a sheet of paper, go through it all with the patient and then until our next follow up appointment, have them say to me that they were 'too busy' or 'forgot' to do the exercises. *Then in my mind I would choke hold them until they passed out*

We must remember that most of our clients are working class people and not elite/super disciplined athletic machines (unless you work in that sort of clinic, of course) and they have a 9-5 job to do during the day. Personally, when I get home from work, the last thing I want to do are 7 of my physio exercises that's going to take me 45 minutes and a protein shake to complete.

One of the most valuable pieces of advice my first boss (Warren Ansell) told me was "Don't give more than 3 exercises." And I carry this out even to this day. A common mistake of a new grad (aka myself 3 years ago) is prescribing too many exercises and and not loading the patient up enough, so not much adaptation of the tissue occurs. Assuming the patient is already at the 'loading up/get strong' phase of their rehab, if you don't provide enough mechanical stress through the muscle/tendon it won't respond accordingly. So if double leg STS is getting too easy, go to single leg! If single leg is too easy, get them to hold onto a kettlebell! Just keep using the basic principle of progressive overload and keep monitoring how the patient pulls up the day after and you'll be sweet. My patient's compliance has gone up SO much after implementing the "less is more" concept and I honestly think it's because I don't assault them with 43 different 'functional' exercises that require a shaker weight and a vibrating platform.

I love the KISS principle: "KEEP IT SIMPLE, STUPID."

When prescribing exercises, you need to think of only 1 factor.

That 1 factor is: Will your patients actually do them?

(Essentially, no matter how good your prescription skills are, if they don't do their exercises, you're wasting your time and energy).

A lot of the time I will straight up ask them, "If I give you 2 exercises to do, twice a week, will you do them?" Some of them will say "YES" and some will say "Nah bruh".

Dan goes back to mental choke hold imagination

quick clinical pearl... I find that if you do a good job with explaining to them WHY the exercises are crucial to their rehab (whether it be insertional achilles tendinopathy or grade 2 ATFL tear), it will help with their compliance. I love using the "Load vs Capacity" diagram, because you allow the patient to see that if they do absolutely NOTHING, their capacity will not go up, therefore you leave the ball in their court.

***Another important clinical pearl is... with some injuries like an acute ankle ligament tear or a super cranky insertional achilles tendinopathy, DON'T WORRY about having to prescribe an exercise yet. *A common misconception I had is that I always HAVE to prescribe some sort of exercise.* This is not always true! Just give them modalities like a heel wedge, boot, strapping tape or even crutches to fully offload and give that joint a cuddle. As a new grad I remember stressing HARD about not prescribing some sort of 'strengthening' exercise. Sometimes all that joint needs, is to chill and let the body do it's thang. EVENTUALLY, when the body is ready, you do want to gradually expose them to load to improve capacity, but if you do this too soon, you'll risk pissing the injury/patient off even more.**

Greg Lehman puts it very simply, "calm sh*t down, build sh*t up!". I also added another one in there which is "EXPLAIN SH*T". Sorry mum, excuse my French.*

Chapter 3 - WHAT EVERY PATIENT NEEDS TO KNOW AFTER THE INITIAL CONSULT

So, I want split this chapter into 3 sections. What your patient should know before leaving their first consult are:

1.) Diagnosis

2.) Prognosis

3.) Treatment Plan/Clear plan of what THEY need to do to fix their problem.

Let's get into the DIAGNOSIS.

In my opinion, the exact diagnosis is not important. But reaching A diagnosis and the way you explain the diagnosis to the patient is SUPER important. Words have power, so it can really build someone up or screw someone up. Whether the patient has a partial thickness tear or irritation of the rotator cuff, it doesn't really matter, because the treatment method is going to be much of a muchness. Same simple theory applies, calm it down, build it up. If you are unsure of the diagnosis, DON'T FRET.

Tell that to the patient. There is no shame in saying "I don't know". However, you should have a couple of differentials in your mind by now, you can share those with the patient, assuming it won't cause an unnecessary fear. You can share them as "theories" to what's causing their pain. If I have no idea WTF is going on, I always tell them, "I'm not sure exactly what's causing your pain, but here are some of my theories..."

I say "theories" because they are meant to be proven wrong. Patients come to YOU for an expert's advice, and want to know what's most likely going on. Just remember, even your educated guess is still better than an uneducated one.

Next thing patients want to know is the PROGNOSIS.

How long is this sucker going to take? This is where I think, unless SUPER confident, always over estimate the time frame.

If you say it's going to take 1 week and it ends up taking 3 weeks, you'll lose street cred. However if you say 3 weeks and it takes 1 week, you're bloody laughing, mate. (How's my Aussie lingo?)

The general rule of thumb that I personally follow is that if the pain comes on over a slow gradual period of time, then it's probably going to take a long time to settle. Vice versa, if the pain is acute, it will probably settle rather quickly.

For instance, an acute ATFL ankle sprain. Day 1: Super duper swollen, hot and angry, patient limps in. How many times would you see them walking with only a minor limp by day 7. On the other side of that coin, someone comes in to see you after having this cranky lateral elbow for the past 6 months and flares only with heaps of gardening. Chances are, they have elbow extensor tendinopathy! And we know that tendons can be temperamental (like my Malaysian wife) and can take up to years to fully settle.

So be realistic with your prognosis and don't underestimate the time frame... is the key takeaway.

Lastly, is their TREATMENT PLAN.

Something that I've learnt only this year, is that if you NEED to see your patient, then you NEED to see your patient. Don't take their financial circumstance into whether you re-book them in or not. If they can't afford it, they will tell you. If the injury is super cranky, then book them in twice that week. Maybe even three times if needed. If the injury is more self-managed e.g mid-late stage ACL rehab, then book them in once a fortnight or however often YOU think is necessary. I think this is where the whole Imposter Syndrome comes alive, and TRUST ME, I've had similar problems where I would have internal voices saying "Don't book them in again, because they have to pay $95 again. I don't want to milk them."

NO!!! This is a wrong chain of thought. You've done your 4 years at university, YOU are a health professional now. The patient doesn't know what's best for them, hence why they've booked in to see YOU. They are putting their trust in YOU as the expert. So if YOU NEED to see them again, then YOU NEED to see them again.

Alongside with the treatment plan, this is where I give them their home exercise plan. I try make it super clear and concise. It could simply look like this:

- **Use crutches as pain tolerated over the next 3 days.**
- **Every 30min, elevate ankle do 30x ankle circles and gas pedal motion.**
- **Come back to see me in 4 days.**

For me personally, my initial patients ALWAYS leave with a sheet of paper. On that piece of paper are 3 questions with an answer on the bottom to each of the 3 questions.

Those questions are:

1.) What's causing my problem?

2.) How long is this going to take?

3.) What do I need to do from here?

Alrighty Fam, I think it's another snack and tea break, because the next section is going to be juicy!! We are going to be chatting about MULAAAA $$$$$.

Stay tuned.

Chapter 4 - PROS AND CONS TO DIFFERENT PAYMENT METHODS

Time for the juicy stuff. Below are 3 of the pay methods we commonly see used in private practice. More info can be found on https://physio-cpd.com/physiotherapist-salary-in-2022/

SALARY ONLY:

You are paid directly on how many hours you are at work. So basically an hourly rate. You are available for Y hours for patient contact, so at the end of the work week you will receive:

Y * $X/hour + super.

Pros:

- **Even if you see 0 patients that week, you can still get paid for however many hours you are at work, so that provides stability for weekly income.**

Cons:

- **Often the hourly rate is not amazing (between $33-34/hr as a new grad). I know mates who pack boxes in a warehouse and earn $40-50/hr.**
- **Often paper work and admin hours aren't included in those paid hours, and trust me, if you see lots of EPC referrals and worker's compensation, the paperwork can stack up.**

SALARY + COMMISSION

You have a base salary and the opportunity to earn a percentage of the consult fee and whichever is higher at the end of the pay week, you will receive that pay.

Pros:

- **Even if you have a crap week of seeing 0 patients, again, you will receive a base level of pay per week. So that gives you**

financial stability to pay rent, eat meat (unless vegan) and buy pumpkin spiced lattes.

- **If you have a cactus week and see HEAPS of patients, then you will be rewarded with a commission on top of your base salary (I was on 40% commission in my first job, which means I was able to take home 40% of the consult fee. You'll have to do some quick maths to work out exact number).**

Cons:

- **Usually the higher the base, the lower the commission will be and vice versa. Each clinic will be slightly different on this one.**

COMMISSION ONLY:

You bring in $X amount revenue to the clinic each week and you take Y% of that amount home.

Pros:

- **The potential to earn loads more dough $$$.**
- **New motivation to perform well because there is a direct correlation between seeing patients and your take home income.**
- **Usually the % of take home pay is on the higher side (>50%)**

Cons:

- **If you see 0 patients that week, well then... you're going to be eating baked beans and Mee Goreng noodles that week.**
- **Higher levels of financial stress related, due to unpredictability of pay each week.**

My 2 cents of advice? I would suggest, when starting out, go to a clinic that values professional development over the clinic that offers a higher pay. Obviously you don't want to be under paid either. Try to find and negotiate that balance with your employer.

I've heard of horror stories of clinics that have their new grad working down to the bone, massaging all day everyday with zero professional development. Yeah, they make money, but what's money if you're hella depressed and have zero professional development, right? Wow... that was deep.. BUT you picking up what I'm putting down, right?

From my personal experience, I was on the Salary + Commission for my first 3 years of work. It did indeed give me a weekly financial stability as I knew I would never get paid below a certain amount, so it made planning and budgeting heaps easier. HOWEVER, I did honestly get to a point where I didn't care if I was making commission or not... because 40% wasn't very high. Obviously, it was slightly nicer than base salary, but wasn't enough for me to really work hard to perform.

So, I was getting to the point of not really caring if patients turned up or not, and had low re-booking rates. Don't judge me, I'm just telling you the truth! Nowadays I'm on a commission only "contractor" pay method and this works for me.

Alrighty, go have a nap and a crack your thoracic on the foam roller.

This final chapter, we are going to talk about EPC and Workers compensation schemes. There are more schemes out there (depending on which part of Australia you live in) but these two gave me the biggest headaches, so we'll just touch on these two for today.

Stay tuned.

Chapter 5 - WORKERS COMPENSATION & EPCs

Ah... the joys of WORKERS COMPENSATION (WC). First of all, what even is WC? Here is the definition by fairwork.gov.au: "WC is a form of insurance payment to employees if they are injured at work or become sick due to their work. WC includes payments to employees to cover their 1.) wages while they're not fit for work 2.) medical expenses and rehabilitation.

It all sounds very lovely and caring right? Well for most of the time, YES it is... but you can get the other side of the coin where the workers get completely screwed over by the system and/or workers completely screwing over the system.

The usual people involved in a WC claim are:

- **You (Absolute legend of a Physio)**
- **The injured worker**
- **The injured worker's employer**
- **The case manager (Usually from an insurance company)**

- The GP
- The return to work coordinator.

word of advice: DOCUMENTATION IS CRUCIAL!!! There was some stat somewhere saying that quite a large percentage (don't ask me the exact %) of these WC claims do end up going to court, and as the treating physio, often you'll have to present all your medical legal documents. So if you don't do your notes because you didn't have 'time' or just a lazy ass, well then... I pray you never have to go to court.

So, this is the usual sequence of events for a general WC claim: Worker gets injured at work e.g rolled ankle whilst climbing stairs -> they report the injury to their supervisor and file a WC claim -> The get booked in with a GP -> GP sends for x-ray and ultrasound to r/o # and a referral for Physio -> worker presents to you 3 days post injury for Physio Mx and Rx -> worker works with you over the next 6-8 weeks -> worker gradually returns to work until they are at full capacity, nil restrictions.

Throughout the process, you keep the case manager, GP and employer in the loop via email giving them updates as you go. Everyone's happy.

OK, I just gave you an example of how I WISH every WC claim would go. Here are a couple scenarios I have personally seen happen...

***There is a cufuffle between worker and employer. Worker reckons they got injured at work, employer reckons they got injured at home and 'faked' the injury at work.**

***The worker suffers a relatively straight forward rotator cuff related injury, fast forward 2 years later, they've had 2 shoulder arthroscopes done, they are still on WC but now have a full blown frozen shoulder. They have tones of psychosocial problems, they've gained 20kg from side effects of the opioids they are on to deal with the pain. They are now at war with WC, dealing with law suits etc.**

I hope YOU will never have to go through that last scenario there.. but just bear in mind that it does happen. Be mentally prepared, like "Captain America about to fight Thanos" prepared OK?

Regarding paperwork from physio, every 8 sessions, you will need to submit a new lot of paper work to get another set of 8 treatment sessions approved from the insurance/case manager. Hence why, keeping good documentation makes YOUR life easier because you know exactly how many treatments they've had and when you are nearly due for another round of paperwork.

Let's chat EPC now.

EPC stands for ENHANCED PRIMARY CARE PLAN. It's a plan on the Medicare Benefits Schedule where GPs are able to plan treatment for patients (Up to 5 consults per calendar year) who suffer from a chronic or terminal medical condition with other medical providers including Physio, Osteo, Chiro, OT, Speechie, Dietitian,

(the list goes on). So basically, to be eligible for the EPC, you need to have a 'chronic' illness e.g more than 3 months. Once the EPC is filled out by the GP, their office will fax a copy of the paperwork to YOU (Physio).

Typically, these patients tend to be more 'complex' as they tend to be older and have an extensive medical Hx. You do also get the 'average' old person who has knee arthritis and been referred to you for strengthening under EPC. Those are a dream. The other side of the coin could be someone who's got 27 chronic illnesses, heavy smoker, alcoholic, Hx of drug abuse, Hx of domestic violence, bipolar (the list can go on). So yeah, have fun with those.

Sorry if I just freaked you out with the horror stories from WC and EPC. However, just remember one thing and that is: "KEEP IT SIMPLE, STUPID." Don't try fix all their issues in one consult. Pick one impairment and try help them there.

Meet your patient at their level and try build them up from wherever they are. I often give these really complex people one thing to do. That could be to walk 5min a day. THAT'S IT. Everyone's goals will be different. Our care has gotta remain patient centred/focussed. No matter how complex or simple their injury are, just remember that YOU are a HUMAN trying to help another HUMAN. With that in mind, hopefully you will approach any case with less stress, an open mind and a warm smile.

Conclusion

Well done, you've reached the end of my very first eBook on "5 THINGS I WISH I KNEW BEFORE STARTING PRIVATE PRACTICE."

I hope after reading this, you will feel sliiiightly more confident in starting or even continuing private practice work. I often think, not all superheroes wear capes, some wear a nike polo and hold a goniometer. I really do love our profession as I think it has so much to offer. I genuinely believe that Physiotherapists are among the most compassionate and empathetic humans in the world. Our ability to connect with our patients at their level and TRULEY listen to their story is second to none. Sometimes, the most powerful tool is a kind heart and hands to help (sorry if I just offended you, if you're an amputee).

So, what's next for me?? I am on the process of creating an online 2-3 hour (Entertaining and Educational) seminar which builds on what this eBook has already covered plus MORE content! Once it's up and running, ya'll can purchase it at a low cost and work through it at your own pace.

My next goal? Glad you asked! I want to create a face to face day workshop in Melbourne and go through the contents of this eBook but in more detail and include more hands on joint Ax/Rx clinical gems.

I have a strong passion in helping students grow in their confidence and knowledge in our profession.

Lastly, if you're a fan of my work, down below are ways you can support me.

- **Follow my Instagram @theflexingphysio for some funny and education physio content.**
- **Follow my PODCAST (theflexingphysio) - avaliable on Spotify and Apple Podcasts**
- **When the online course becomes live, buy it and help me spread the word to whoever may benefit from it.**

God Bless <3

The Flexing Physio