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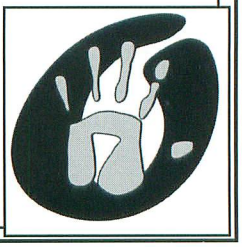

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- Advancement of education and clinical practice,
- Facilitation of quality research, and
- Professional development of members.

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Editor's Message

Blooms and Buds and Such

Welcome Spring! All around us, we see images of beginning again. This is the time of year (at least down South) when we begin to see the trees budding, the daffodils bloom, and the green shoots of the tulips begin to break through the ground. Growth and change are abundant. So too, we see growth and change for the Orthopaedic Section. We have begun a new season under new leadership. We are hopeful that it will be even more abundant than was the last. Many thanks are due our past president, Bill Boissonnault and past Vice President, Nancy White, for the tremendous job they did these past 6 years. Thank you both for your vision, leadership, and guidance, as well as the opportunities you gave to so many.

As we welcome the signs of spring, we also welcome our new leadership under the direction of Michael Cibulka, President and Lola Rosenbaum, Vice President. With them, we have new hopes for what we can accomplish as a Section. One large item on the agenda will be assisting the Foundation in reaching its goal of establishing a Clinical Research Network. This network holds new promise for the entire profession of Physical Therapy, and the Orthopaedic Section must continue its leadership in supporting the Foundation. We can only imagine the fruits of that garden!

In considering this mark of time, this changing of seasons, I think of the Elton John song "Circle of Life" and remember my grandmother. The phrase "circle of life" conjures up many images, but most particularly the cyclical nature of life and time. I picture the diagram in my Biology textbook that describes the life cycle of a cell. Then, I consider the life cycle of an individual. We are born, we live, and we die. What we do between life and death determines who we are. The choices we make and the example we provide to others define our lives. The choices we make collectively define our organization. Fortunately, we have the opportunity to learn from others so that we can make good and informed choices. What can we learn from our past? When I ask myself this question, I again think of my grandmother—"Granny Nurse." She was a wise woman who made her own way. What did I learn from her? The lessons were good and many. Here are some tidbits.

Work hard. Enjoy life and live it to its fullest. Don't forget to dance..."Alley Cat" is always a good tune! Red lipstick and "sugar" won't hurt anyone—but shots hurt a little. Try your best to end each day without regret. Do the best with what you have, but work hard. Teach others what you know. You have the power to change your situation. You *can* make your own way. Take responsibility. Love life. Share what you have, even if it is not much. Be sociable. Help and take care of other people. Be kind to people and animals. Take time to visit.

These words ring true about life and work. Consider our lives as physical therapists and physical therapist assistants. Some of our greatest moments come in the smallest of accomplishments. Those "small" victories, like helping a person learn how to walk again, are the moments that make our work so meaningful and enjoyable. In our individual lives as therapists, these words and ways can guide us. But what about our collective lives in physical therapy? Can these pearls of wisdom shared by my grandmother help us there as well? I think they can.

Work hard. Be active in your local/district/state chapter of the APTA. Participate in the organization, write a senator, talk to a representative, volunteer to provide them with information about health care issues. Let people know you are a physical therapist or physical therapist assistant. You (we) can change your (our) situation. Certainly, we have had a recent taste of that with Virginia passing a new practice act allowing direct access! Teach others about physical therapy—and that we are the only ones who can provide it! Take responsibility, in both our professional and personal lives. Be kind to people and animals—yes, animals. Take time to visit—with our patients and with each other. The conversations with other professionals, like at CSM, offers great opportunity for renewal. Try to end each day without regret—be grateful for each opportunity that passes your way and for every time you help to make someone's life a little easier. These wise words of experience certainly provide me with guidance, not only this spring, but throughout the year.

In this springtime issue of *OP,* Pam Duffy has provided us with a case study highlighting an alternative practice environment. Steven Lesh also provides a very pertinent article regarding the use of people-first language.

In addition to our feature articles, this issue also includes 2 articles in the "Practice Affairs Corner." I encourage you to read these, as I expect they may generate come conversation, if not controversy. Once again, the SIG newsletters are full of information from CSM, including election results, plans for the future, and articles related to CSM programming.

In the wonderful words of my grandmother, both spoken and lived by her, "Enjoy life and live it to its fullest!"

Susan A. Appling, PT,MS,OCS
Editor, OP

President's Message

Orthopaedic Physical Therapy Dreaming

I, like most everyone, have both good and bad dreams at night. A favorite dream I often have is about how life would be if all patients had direct access to physical therapists and also how I as a physical therapist would work. I dream that as I am taking my patient's history, I adroitly pick the best questions that quickly lead me to the important symptoms that guide me in selecting only the best tests or measures, that results in finding my patient's diagnosis. Each test, of course, would have "high" specificity and sensitivity that would easily confirm my diagnosis (I am dreaming, remember). My intervention would significantly improve the quality of life in my patient. The final part of my dream (this is where I usually wake up, often in a cold sweat) is that the third-party payor pays me quickly and fairly for my beneficial, safe, and effective service. (If I make it to this point in my dream the kids and the dog always like me much better in the morning, not to mention my wife.) Ahhh....life is good.

So what's wrong with this dream? Nothing, except for the fact that it's only a dream. We are still far off from this dream turning into reality. I believe there a great number of reasons for my sleepless nights. First, although we do have some information regarding which factors in a patient's history are important and how that information relates to a specific condition, we woefully lack concrete evidence. For example, how do we really know that a specific piece of the history is related to a specific condition or diagnosis without data. Most of us have clinical experience and this is at least a start. David Sackett, in his book *Evidenced Based Medicine* (EBM), calls this sort of information pretest probabilities. Pretest probabilities often come from experience. For example, my experience tells me that pain in or around the posterior superior iliac spine is often, but not always, related to sacroiliac joint dysfunction. Next, Sackett suggests that pretest probabilities should be combined with evidence from a useful test (a test or cluster of tests that can confirm or refute a specific diagnosis/condition that have high likelihood ratios, sensitivity, and/or specificity that pushes us over the treatment threshold). Pretest probabilities are used to increase the prevalence of a disease or condition to reduce the number of false positive test results. Here is where we as physical therapists really need help, since we have very few excellent clinical tests that can confirm or refute a diagnosis.

I believe the time has come for us to move beyond just reliability studies. I am not saying that the ubiquitous reliability study for a test or measure is not important, I am just saying that I would rather have a useful test with moderate reliability than a very reliable test that has no clinical utility (here I go again dreaming). In our occasional myopia we often fail to determine if these reliable tests really mean anything to us. Reliability can often be improved, while the utility of a test cannot. Useful tests often come from observed phenomena during clinical practice. An example of this is the Apgar test. The Apgar test, which is used to assess newborn response, interestingly was put to use before any reliability studies were ever performed. The immediate usefulness and relative transparency of the Apgar test was obvious to clinicians. We, however, must be careful that we don't embrace every nascent test that comes out, lest we be viewed as naive, or worse a charlatan. Using unproven, unreliable tests, especially in patients with life threatening conditions, is irresponsible and risky. Luckily, most of the orthopaedic conditions we see are not life threatening and the risks involved with therapy are usually not high, while the benefits are often outstanding (relief of pain and improvement in the quality of life...now I remember why I like this job). We must decide what the utility (clinical usefulness) is of the tests we commonly use. *Does the test (or cluster of tests) help us guide our interventions or help us make a prognosis? If not, why are we using it!? The most important decision when picking a test is whether or not the patient is better off because of the test.* Now for me, all I want is one, maybe two 100% reliable, valid, sensitive, and specific tests for just the 10 most common diagnoses I see in my clinic. I would wake up every morning happy, happy!

Beyond tests and measures we have a huge void in proving our interventions work. No wonder I wake up in a cold sweat after these dreams. We need evidence! What is and what isn't an effective physical therapy intervention? How can we ever demand better reimbursement rates without this basic evidence? Good evidence will allow us to negotiate with payors from a position of strength, not weakness. Many of the research questions I discussed are already in APTA's new Clinical Research Agenda; we will use the Agenda to help guide Orthopaedic Research. Also, the Foundation for Physical Therapy introduced its newest method to help find solutions to the sort of problems I described in my dream; it's called the Clinical Research Network (CRN). At CSM the Orthopaedic Section Board of Directors decided to donate a substantial amount of money to help get the Network funded. Also, we as individuals decided to personally donate a significant amount to the Foundation. We want to lead by example. **My dream is that every member would donate somewhere in the range of $10 to $100 to the Foundation, which can be designated for the CRN.** If you donate, I thank you in advance for your perspicacity and generosity. With your support you will lead the way in making all of our clinical dreams come true. The Orthopaedic Section will do its best to support this and all research projects that will improve orthopaedic clinical practice—this is one of the Section's major objectives. Please show your support; I hope we can get 100% participation from our membership.

Enough dreaming. Now that I am wide awake and ready to go, I would like to thank our recent past President, Bill Boissonnault for all of the hard work he has put in over the last 6 years. Also, a special thanks for making the transition easy. Bill, we will miss your calm, soft spoken, thoughtful, sagacious, and caring demeanor at the Board of Directors Meetings. Second, I would like to thank the Section office staff for all of their hard work. Lola Rosenbaum (your new Vice President)

(Continued on page 12)

Case Study of Patient with Traumatic Fracture of the Proximal Humerus, 1-Year Postinjury

Pamela A. Duffy, PT, OCS, RP

ABSTRACT

Long-term follow-up of patients or specific patient populations is not reported with great frequency in physical therapy literature compared with literature in orthopaedic surgery or other areas of medical practice. The failure of clinicians to perform longitudinal clinical follow-up and report the findings has created a significant gap in the knowledge base of the profession and affects both didactic and clinical education of physical therapists. The purpose of this case report is to stimulate dialogue among orthopaedic physical therapy practitioners about the utility of long-term follow-up with patients of various diagnoses or impairment pattern classifications as well as describe a modification of the standard posterior glide mobilization/manipulation technique to the glenohumeral joint.

INTRODUCTION

With the influence of managed care, third party reimbursement of physical therapy services has declined and the wisdom of entering into or continuing in private practice has been questioned by some physical therapists as well as physical therapy students about to enter their first practice experience. However, despite some general discussion about the practicality of first-party reimbursement, there remain questions about the viability of self-pay as a means of economic support for medical professionals. This case study is an example of a direct relationship between the physical therapist and the patient that can be enjoined and the benefits of such a professional relationship. With the passage of the Position on Direct Interventions Exclusively Performed by Physical Therapists (HOD-06-00-30-36) at the 2000 APTA House of Delegates, it is important for the profession to examine the impact and implications of this position on practice. In this case study, the importance of the direct procedural intervention of manual therapy, specifically joint mobilization/manipulation, is emphasized. Joint mobilization/manipulation performed by the physical therapist was key in progressing the patient towards the mutually agreed upon goals and realistic treatment outcomes. Finally, the utilization of the *Guide to Physical Therapist Practice*,[1] both concurrently and retrospectively, as a resource and documentation tool emphasizes the necessity of life-long learning.

REFERRAL, COMMUNICATION, AND DOCUMENTATION OF EPISODE OF CARE

This patient was referred by her orthopaedic surgeon for treatment of a traumatic proximal humeral fracture following 5 weeks of immobilization in a shoulder immobilizer. There was a period of 7 weeks between the date of injury and initiation of physical therapy. Since Iowa is a direct access state, the patient was able to seek out her own physical therapist. Because the patient sustained this injury in a fall while performing volunteer work, the liability for the personal injury was relegated to the property owner. As a result, the patient, a Medicare beneficiary, was not restricted to utilizing a Medicare-certified facility. The correspondence and medical documentation occurred primarily between the physical therapist and the orthopaedic surgeon. The patient assumed responsibility for payment of physical therapy services. After submission of medical records, she was fully reimbursed for billed charges by the property owner's liability insurance company.

COURSE OF PATIENT MANAGEMENT

The initial examination (See Appendix) to establish goals and initiate care was performed in the patient's home. Throughout the course of care, the patient was able to demonstrate progression toward her goals in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) by using familiar objects in the actual environment in which she lived. Each physical therapy visit was 45 to 60 minutes during the first 6 weeks and 30 to 45 minutes during the last 6 weeks of care. At discharge, the patient was continuing an active home exercise program in both cardinal and diagonal movement patterns. Very few exercises were progressed to utilizing light weight resistance of 1 to 2 pounds maximum. At discharge, the patient's endurance was considered poor and limited to 1 set of 10 repetitions followed by 1 set of 5 repetitions for each active exercise without resistance. The severity of her muscular weakness and lack of muscular endurance for exercise were considered complications to this case and attributed to the comorbidity of childhood poliomyelitis. The clinical presentation was postpolio-like symptoms in response to exercise as manifested in muscular weakness of the scapular stabilizers, rapid fatigability of the shoulder girdle musculature, and aching in shoulder girdles bilaterally. One month following discharge, the patient was participating in a community-based exercise program conducted by this physical therapist. It consisted of 12 group sessions of T'ai Chi Chih', a variation of T'ai Chi, at a frequency of 3 times per week, for 4 weeks. This allowed the patient to continue strengthening and endurance training of functional movement patterns in a supervised environment.

The total number of visits for this case was 25. The *Guide to Physical Therapist Practice*[1] states that for pattern 4-G Impaired Joint Mobility, Muscle Performance, and Range of Motion Associated with Fracture, 6-18 visits are the general recommended range of visits for 80% of all patients in a single episode of care. For the pattern 5-G Impaired Motor Function and Sensory Integrity Associated with Acute or Chronic Polyneuropathies, a range of 6-24 visits are recommended for 80% of patients. Retrospective review suggests that the weakness of the scapular stabilizers as a result of childhood poliomyelitis contributed to the difficulty in shoulder girdle strengthening to accomplish functional goals and progress patient toward an independent home exercise program. In addition, the involved upper extremity was the patient's dominant upper extremity. This was a key variable in determination of long-term functional goals and readiness for discharge.

The primary complaint of pain con-

sisted initially of global shoulder girdle pain, and then became more band-like pain in the arm at the deltoid area. This pain progressed to what the patient described as aching and stiffness of the joint.[2] As would be expected, the most rapid progress was made during the initial 4 weeks of care as the patient was weaned from the sling, as well as progressed toward active-assistive and active exercise in gravity-eliminated positions. Impingement type pain was present most significantly at the 6-week mark in the episode of care. At the 8-week mark, the key intervention was anterior-posterior glide of the glenohumeral joint used to achieve normal joint play. This technique was modified from a supine to a sitting position due to ineffectiveness and patient apprehension (Figure 1.) Numerous orthopaedic texts describe this maneuver as one in which the patient is supine and the physical therapist is standing. The advantages of the sitting position include gravity-assistance in long axis distraction of the humeral head from the suprahumeral structures, the physical therapist's greater ability to vary the amount of force in the mobilizing arm, and patient relaxation. As noted in Figure 2, at the treatment session in which the anterior posterior (A-P) glide was modified, the patient experienced immediate ability to actively flex and abduct the right shoulder to 0-150° without pain. Flexion and abduction had previously been painful actively as well as passively at the endrange. In addition, prior to the modified A-P mobilization/manipulation, the clinical examination of the patient produced pain and spasm with overpressure in flexion. The most significant improvement following modified A-P mobilization/manipulation was in the active Appley's internal rotation test so that the patient was able to independently reach to T11 of the spine without pain and "popping." Previously, the patient's reach was limited to L1 with difficulty, pain, and audible and palpable crepitus. The ongoing, continuous, and simultaneous re-evaluation by the physical therapist was critically important to progress the patient appropriately. With modification of the manual therapy techniques in sitting for the desired therapeutic effects, the frequency of treatment was decreased to weekly, and only 3 additional visits were required until discharge. The patient was progressed to a home exercise program that could be performed by the patient with minimal discomfort during exercise and without symptoms of joint inflammation or delayed onset muscle soreness. Figure 2 provides a summary of physical examination, symptoms, functional changes, frequency, and total visits.

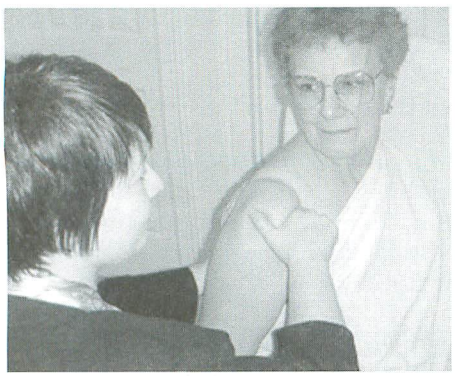

Figure 1. Photograph showing hand placement for modification of the A-P glide with the hand placement of the mobilizing arm at the proximal humerus and the stabilizing hand at the axilla and scapular area.

SUMMARY OF OUTCOMES AND CONTRIBUTING INFLUENCES

This case illustrated several general principles of orthopaedic physical therapy:

1. The patient and the physical therapist had a high level of communication and interaction during this episode of care, which contributed to reported patient satisfaction.
2. The physical therapist's accountability was to the patient. One aspect in which this was demonstrated included the patient's responsibility for payment for all care. The patient negotiated reimbursement to herself with the payer. Extraneous influences of limited visits or reimbursement imposed by managed care contracts or other payment schemes were removed and positively influenced the patient's outcomes.

Measure	01-05-00	01-31-00	02-25-00	03-07-00*	03-27-00	01-24-01
Pain with movement (VAS)	5/10 Has used RX pain meds prn through start of PT.	Daily OTC meds in a.m. for pain. Episodes of severe pain. Cannot sleep on right side.	OTC meds for weather related joint pain only prn.	1-2/10 Awakes if rolls onto right shoulder.	0/10 Sleeps on right shoulder with fair tolerance.	0/10 Sleeps on right shoulder ad lib, no symptoms.
PROM Flex	0-75P	0-150	0-140 (exac. In Feb.)	0-150 P: no pain after mob	0-170	0-168
Ext	0-15P	-	-	-	-	0-67
ER	0-20P	0-40P	0-60	-	0-80	0-81
IR	0-30P	-	-	-	-	0-62
Abd	0-45P	0-100P	0-120	-	0-175	0-175
Active Appley's IR	Grt troch	Glut. Fold	S-I	L1—to T11 after mob	T11	T4
Strength	2-/5	3+/5	-	4-/5	4-/5	5/5
Interventions	Ice massage, Soft tissue and joint mobilizations, pendulum exercises.	Ice and ultrasound for exac. of joint symptoms with manual therapy and ther ex.	Exac. of shoulder pain as exercise progressed relatively minimal to moderate manual resistance.	Soft tissue mob, ***modification of A-P glide,** joint Mob/manip AAROM and AROM right shoulder girdle.	Home program continues with 1-2# qd for 1 to 2 months. T'ai Chi Chih May 2000 for 12 sessions.	None. No medications.
Functional status/gains	Dependent ADLs including personal care and dressing. Can carry <5# in right hand at side or (B) front carry.	Can comb hair, can reach into cupboard; independent in all ADLs except fastening bra.	Driving automobile, typing at computer keyboard, light housecleaning.	Cannot fasten or unfasten bra behind back. Can play dulcimer without restriction.	Can unfasten bra behind back. Uses left hand to assist right hand to fasten bra behind back. (B) front carry 10-15# at waist level.	Performs 30 reps AROM, BID for weather related joint stiffness prn. No deficits in ADLs, avocational and IADLs. (B) Front carry 20-25# at waist level.
Frequency Visit #	3X/wk 1	Decrease to 2X/wk 11	Continue 2X/wk 17	Decrease to 1X/week. 22	Discharge 25	1 yr F-up N/A

*Point at which A-P glide of G-H joint was modified to sitting position.

Figure 2. Clinical progression through episode of care compared to 1-year follow-up.

3. The physical therapist was highly involved in the ongoing examination and re-evaluation of the patient during each visit, as well as in toto. The patient's entire plan of care was modified to meet the physiological and functional changes that occurred from visit to visit during the episode of care. In this case, all care and interventions were provided by the physical therapist. The comorbidity of postpolio weakness complicated this particular case and required consistent, high level physical therapist involvement at each visit and during the entire episode of care.
4. Treatment goals and projected outcomes were individualized, as noted in Appendix, to take into account the specific characteristics and individual differences of this patient. Of particular note was that, although elderly, this patient was as active and involved in home and community life as might be expected from an individual 20 years her junior. Her IADLs were a significant portion of her psychological, intellectual, and social life and included physical and functional components. It was even further accentuated by the fact that the involved upper extremity was her dominant arm. Appropriate physical therapist patient management was critical to identifying and defining appropriate physical therapy goals and determining an endpoint to care. The physical therapist was very aware that for a less active person, the episode of care would most likely have been terminated earlier because the prognosis, expectations, and motivation of the patient may have been lower or less complex.
5. Even though there were functional and physiological deficits at time of discharge, this case study has documented obtainment of long-term goals during the intervening year from discharge to present. Clinical decision-making, physical therapist judgment, and patient education were required to determine the agreed upon endpoint of the episode of care.

CONCLUSION

There are many opportunities for the profession to engage in longitudinal studies of "typical" cases as well as exceptions or outliers. Orthopaedic surgery, for example, routinely follows and documents procedures and cases over several years or longer. Wherever possible, physical therapists should be contributors to studies of long-term functional outcomes by establishing long-term follow-up as a routine part of their practice. Physical therapy data must be collected and published to objectively establish the critical points of clinical decision making that influence patient management and at what point an episode of care can be terminated while still resulting in optimal patient function and satisfaction.

REFERENCES

1. American Physical Therapy Association. *Guide to Physical Therapist Practice.* 2nd ed. Alexandria, Va: 2001.
2. Maitland GD. *Peripheral Manipulation.* 3rd ed. Butterworth-Heinemann Ltd; London, England: 1991.

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Appendix. Patient examination and plan of care, re-examination and goal revision, and discharge medical record entries.

January 5, 2000 Tuesday
Setting: Home
Initial Examination and Evaluation: Patient Name
Date of Birth: July 20, 1929
Date of Injury: November 19, 1999
Primary Medical diagnosis: Fracture right proximal humerus
Pattern: Impaired Joint Mobility, Muscle Performance, and Range of Motion Associated with Fracture 4-G
ICD-9 Code: 812.0

This patient is a 70-year-old white female in generally good health with the chief complaint of right shoulder and upper extremity pain and limited motion due to fracture of her right shoulder which occurred on the evening of November 17, 1999 when she fell landing on her right upper extremity after her shoe hit a raised piece of cement sidewalk causing her to trip. She was in immediate pain and was seen at a local hospital. She is referred to physical therapy by her orthopaedic surgeon. She will see him again in 4 weeks. She denies previous history of right upper extremity injury. She is right hand dominant. She was initially treated with a shoulder immobilizer for 5 weeks and then a sling at all times until December 22, 1999. She now wears the sling prn. Prescription pain medication has been gradually diminished. Pain level is mild at rest of 1-3/10 and moderate to severe with active motion of 5/10 or greater. Most times, she is taking 2 aspirin for pain as needed. Past medical history includes polio as a child with mild residual weakness in the thoracic and scapular musculature; wears eyeglasses. No current illnesses noted. Social/vocational history: she is retired from office work and English teaching. She is a parliamentarian and active in her church. She lives with her husband in a 1-story ranch style home with 2 stairs into the house, and basement stairs. Both the patient and her husband are active in volunteer work and their church, as well as play dulcimers. Prior to this injury she was independent in all ADLs, driving an automobile, housecleaning, playing piano, dulcimer, typing at computer, cooking, carrying groceries.

Additional complaints related to previous functional level:
1. Dependent in upper extremity dressing

2. Unable to prepare meals
3. Unable to sleep on the right side
4. Unable to lift and carry any item over 5 pounds
5. Unable to raise right arm to apply deodorant; or reach across body to left axilla
6. Unable to reach into cupboard
7. Unable to drive automobile
8. Unable to play dulcimer
9. Unable to move recliner up and down with right hand control
10. Unable to perform housecleaning

Objective examination of the right upper quarter:
Cervical spine cleared. Mild tightness in the paracervical musculature with sidebending and rotation to each side but no referred pain to the right shoulder.
Neurological examination is negative.

PROM of the Right Shoulder (Compared to the Left shoulder):
Flexion: 0-75 with pain at endrange before resistance (0-170): -95°
Extension: 0-15 with pain at endrange before resistance (0-70): -55°
Abduction: 0-45 with severe pain with resistance (0-180): -135°
Adduction: 0-5 with pain (0-60): -55°
External Rotation: 0-20 with pain before resistance (0-90): -70°
Internal Rotation: 0-30 with pain at endrange (0-70): -40°

Note: full active and passive range of motion noted in the right hand, wrist, and elbow with mild tightness of the biceps.

Right Upper Extremity Strength compared to left upper extremity all 5/5:
Shoulder: 2-/5 with pain
Elbow: 3+/5
Wrist: 4-/5
Grip: 4-/5

Interventions: With patient seated, ice massage applied to the right shoulder, scapular musculature, and biceps until anesthesia to light touch approximately 10 minutes. Patient and her husband instructed in how to apply cold at home for pain and following home exercise program. Gentle joint mobilization Grade I performed for inferior glide with patient in a seated position. Patient instructed in and performed Codman's exercises. To be performed q.i.d. until next visit. Patient instructed in Wall Walking with the right hand on wall—able to get to shoulder height only. Patient had moderately severe pain with this activity. Patient is to attempt this with home exercises 2 to 3 times per day total of 5 times each session. Gentle PROM performed to the right shoulder and AAROM performed to the elbow with gentle biceps stretch as well.

Assessment: Patient's impairment related to fracture, muscular weakness, capsular restriction in right shoulder girdle with limitations in ADLs, instrumental activities of daily living, avocational and vocational activities with mild to moderate pain. Patient's prognosis to return to full function is good to excellent. Husband is able to assist as needed with ADLs and other household functions.

Short Term Goals to be achieved by January 31, 2000:
1. Reduce pain to 3/10 at endrange
2. Flexion to 100° or more actively and 120° passively
3. Improve strength to 3-/5 or greater in shoulder girdle musculature
4. Independent ADLs like using toothbrush, combing hair, dressing except for fastening bra behind back
5. Use eating utensils to eat with right hand
6. Automobile driving

Long Term Goals to be achieved by March 15, 2000:
1. Fasten bra behind back independently
2. Sleep on right side without symptomatic problems that affect function
3. Play the dulcimer with both hands
4. Moderate housecleaning
5. Strength of the right shoulder girdle to 4/5 or greater
6. Flexion of the right shoulder to 0-165° or better actively

PROGNOSIS: Good to achieve all goals.
Plan of Care: Patient will be seen for 3 visits per week for the first 1 to 3 weeks and then tapered off to twice per week for the next month, and eventually to 1 time per week or less for conclusion of care to achieve long term goals. It is expected that modalities of

ice and ultrasound will be utilized for the first several visits to facilitate joint mobilization and therapeutic exercise regime. Eventually modalities will be discontinued as patient's acute soft tissue signs and symptoms subside.

Pamela A. Duffy, PT, OCS, RP
Iowa License Number: XXXX

January 31, 2000 Patient: Name
Referring physician: Orthopaedic Surgeon
Diagnosis: Fractured right proximal humerus
Impairment: Capsular restriction resulting in loss of shoulder range of motion, muscular weakness, and loss of function

Physical therapy interventions: ice massage and ultrasound for acute musculoskeletal inflammation and to improve capsular stretching and mobilization; joint mobilization and progress of range of motion activities and home instruction to regain active movement and strength of the right shoulder; instruction in self-management techniques and home exercises.

Total visits from January 5 through January 31, 2000: 11

PROGRESS since initial examination of January 5, 2000:
1. Improved passive right shoulder flexion from 0-75° to 0-150°
2. Improved passive abduction from 0-45° to 0-100°
3. Improved strength from 2-/5 to 3+/5
4. Improved reaching overhead from unable to able to comb hair and perform ADLs independently

Update of short-term goals for one month (February 29, 2000):
1. Lift and carry objects of 20# such as groceries
2. Fasten brassiere behind back
3. Housecleaning
4. Play dulcimer as hobby

PROGNOSIS: Excellent

Comments: Difficulty has been encountered with exacerbations after each increase in progressive strengthening. Overall progress has been excellent.

Plan of care update: Continue physical therapy visits 2 times per week for additional 1 month to progress strengthening program and difficulty of home exercises with modalities used to prepare tissue for stretching and/or alleviate soft-tissue inflammation/ exacerbations produced as therapeutic exercise program progressed.

Pamela A. Duffy, PT, OCS, RP
CC: Orthopaedic surgeon

March 27, 2000 Patient Name Discharge Note

S./ Doing well and feels that she can continue home exercises on her own. Still cannot fasten her bra behind her back but can unfasten it. She continues to work on this ADL function. She is performing kitchen activities and food preparation independently. Can carry items of 10-15# but not heavy bags of groceries.

O./ Treatment: Joint mobilization in Grade III and IV. Aggressive soft tissue mobs to the shoulder girdle and manual stretching to the endrange and into resistance. Review of home exercises to be performed including active exercises with 1-2# only and not heavy weights due to postpolio signs at thoracic and scapular areas.

A./ Re-examination: Appley's internal rotation is to T11 and passively to T9 and continues to improve. She is gaining on ability to fasten bra behind her back. She can unfasten the bra easily but moderate difficulty attempting to fasten and uses her left hand to assist. Her other long term goals have been essentially met as she is able to drive, plays the dulcimer, and participates in all desired activities. She still has a high level of fatigue and is seeing her family physician for this. She is pleased with her outcome. PROM of the right shoulder is now 0-170° flexion. She is 0-80° in external rotation and this is very functional for her.

P./ Continue home exercises 1 time per day for next 1 to 2 months. Patient may participate in light recreational exercises such as T'ai Chi Chih' as she has discussed with this therapist. She should call if she has any further questions or concerns. Discharge with status considered rehabilitated, long term goals achieved.

Pamela A. Duffy, PT, RP
Iowa License Number XXX
CC: Orthopaedic surgeon

(Continued from page 6)

and I spent a few days watching our staff at work in January during our orientation and discovered just how great of a job they do and how lucky we are to have them. Thank you.

Finally, I would like to thank all of our members (not just the ones that voted for me). I am happy that we have a very dedicated, loyal membership that continues to grow. If you have an idea, let me know. I want to be responsive to your dreams also.

I close with, perhaps, my favorite dream quote from the late President John F. Kennedy who said: *"Some men see things as they are and ask why, I dream of things that never were and ask why not."* Please come dream with us as we embark on a new dream. Why not?

Michael T. Cibulka,
PT, MHS, OCS
President

AAOMPT 2001 — CALL FOR ABSTRACTS

The 7th Annual Conference of the American Academy of Orthopaedic Manual Physical Therapists will be held October 19-21, 2001 in beautiful San Antonio, TX. Interested individuals are invited to submit abstracts for presentation in slide or poster format. The AAOMPT research committee chairman must receive the abstract and 1 photocopy, by **June 1, 2001**. Abstracts received after this date will be returned. You will be notified of the acceptance/rejection of your abstract in July of 2001. If you have any questions call the research committee chairman at (210) 221-8410 or -6167 or email at:
Timothy.Flynn@cen.amedd.army.mil

CONTENT. The Academy is soliciting all avenues of research inquiry from case-report and case-series up to clinical trials. The Academy is particularly interested in research evaluating intervention strategies using randomized-controlled clinical trials. The abstract should include 1) Purpose; 2) Subjects; 3) Method; 4) Analyses; 5) Results; 6) Conclusions; 7) Clinical Relevance.

PUBLICATION. The accepted abstracts will be published in ***The Journal of Manual & Manipulative Therapy***, which has readership in over 40 countries.

SUBMISSION FORMAT. The format for the submitted abstracts is as follows:
The abstract should fit on one page with a one inch margin all around. The text should be typed as one continuous paragraph. Type the title of the research in ALL CAPS at the top of the page followed by the authors' names. Immediately following the names, type the institution, city, and state where the research was done. Please include a current email address where you can be contacted. Also include a computer diskette with the abstract in MS Word format.

PRESENTATION. The presentation of the accepted research will be in either a slide or poster session. The slide session will be limited to 15 minutes followed by a 5-minute discussion, this session will be primarily for research reports and randomized clinical trials. The poster session will include a viewing and question answer period and will be primarily for case report/series.

RESEARCH PRESENTATION AWARD. The research platform presentation deemed of the highest quality of those presented at the annual conference will be awarded the AAOMPT Excellence in Research Award. This award will consist of an award certificate and reimbursement of the conference registration fee.

SHIPPING. To prevent damage, insert cardboard backing in the envelope with the abstract, diskette, and copies. Mail to the AAOMPT research committee chairman at:

LTC Timothy W. Flynn, PT, PhD, OCS, FAAOMPT
U.S. Army-Baylor Graduate Program in Physical Therapy
ATTN: MCCS-HMT (AAOMPT Research)
3151 Scott Road, Room 1303
Fort Sam Houston, TX 78234-6138

To receive notice that your abstract was received by AAOMPT, please enclose a self-addressed and stamped postcard with the abstract or preferably an email address where you can be reached. Your abstract will be assigned a number and you will be notified electronically or via the postcard.

Orthopaedic Section Supports Foundation for Physical Therapy's Clinical Research Network

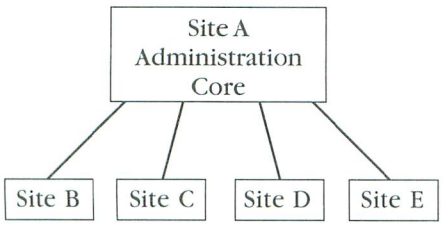
Nancy T. White, PT, MS, OCS

The Orthopaedic Section has historically been a major supporter of the Foundation for Physical Therapy. The Section has funded significant portions of the Foundation's Clinical Research Center, which is completing its final year of a 3-year grant to study low back pain. Additionally, the Section has provided funds for 5½ individual grants at $40,000 each for research to evaluate the effectiveness of physical therapist interventions in patients with musculoskeletal disorders. The Board of Directors of the Section has regularly supported the Foundation in its many fund raising activities such as the annual Silent Auction and Dinner and the split raffle.

At its recent meeting at Combined Sections Meeting, the Orthopaedic Section Board of Directors voted to provide significant funding to the Foundation for Physical Therapy's proposal for a Clinical Research Network (CRN). The purpose of the CRN is to promote collaborative research to evaluate the effectiveness of physical therapy practice. This article will describe the CRN so that Section members will understand its importance to physical therapy practice and will become enthusiastic supporters of this new project.

EXAMPLE

Clinical Research Network



BACKGROUND

The APTA has developed a Clinical Research Agenda that is designed to support physical therapy clinical practice by facilitating research that is useful primarily to clinicians. Evidence-based practice requires the integration of clinical expertise with available evidence from systematic research. In everyday practice, a physical therapist often faces a lack of evidence to support interventions. The Foundation intends to support APTA's commitment to evidence-based practice by developing networks of research centers focused on examining the effectiveness of physical therapist interventions to enhance physical therapy practice.

SCOPE

The Foundation will solicit applications for the CRN in a 2-step process. In the first step, letters of intent will be solicited. Those investigators interested in participating as a network will submit letters of intent to apply for planning grants. The purpose of the planning grants is to provide resources for groups to meet and develop comprehensive applications for the CRN. In step 2, the groups that receive planning grants will be the only investigators who may submit proposals for the CRN.

It is expected that the proposed CRN would fulfill the following objectives:

1. Support research projects that address critical questions outlined in APTA's Clinical Research Agenda. The CRN will focus its questions around a specific theme that will be of the highest priority in physical therapy, affect the widest scope of physical therapist practice, and focus on the effectiveness of physical therapist interventions.

2. Promote collaborative research among investigators in a variety of physical therapist clinical practice areas including orthopaedics, neurology, geriatrics, pediatrics, cardiovascular, pulmonary, and sports physical therapy.

3. Provide a multi-site environment that both develops established investigators and attracts promising new investigators.

4. Foster the most effective and efficient use of financial resources provided to the Foundation.

STRUCTURE

The Clinical Research Network will consist of a coordinating center, which will be the applicant organization, and at least two other satellite sites. Satellite sites must be separate entities from the applicant organization. For example, each satellite site may be a separate university or research center and each will have its own principal investigator with demonstrated experience with the research process through a history of publications, presentations, and grant funding. Each satellite site is encouraged to utilize additional satellite sites of their own for purposes of data collection and other appropriate uses.

Plans for collaboration among the various sites and use of shared resources and patient data is required. The CRN will address research questions around an overarching theme. However, it is expected that each satellite site will have specific questions of its own related to the theme that it will wish to answer.

EXAMPLE

The following example is provided to more clearly describe the structure of the proposed CRN. This is only an example and does not indicate the preferences of the Foundation's Board of Trustees.

The overarching theme could be a major impairment such as muscle weakness. All sites could be collecting data related to frequency, duration, and dosage of physical therapist interventions to address this impairment. Additionally, Site A may be focusing upon stabilization training for lower back pain, Site B may by addressing head control in infants, Site C may be interested in ACL rehabilitation, and Site D may be investigating the importance of strength training in decreasing falls in the elderly. All sites are looking at interventions to address muscle weakness but each site has a different clinical focus.

The benefits of this type of network are numerous. The relevance of the research projects could be enhanced by the increased sample sizes available

through a network. Several different projects can be addressed simultaneously. The experience of working together in a collaborative manner should enhance the network's opportunity to obtain additional, significant outside funding.

SCHEDULE

The Request for Applications will be released when at least 50% of the funding for the CRN has been committed. The Foundation is working hard to raise this money with the hope that funding for the CRN can begin toward the end of 2002.

COST

The projected cost of the Clinical Research Network is $1,825,000. This includes $25,000 for planning grants, 3 years of funding for the CRN at $500,000 per year, and administrative support for the Foundation including the hiring of a scientific program officer to oversee this and other programs funded by the Foundation.

The Foundation is requesting funds from sources within and outside the APTA. Sections, Chapters, and individuals are being asked to contribute. Corporations have been formally contacted and significant donations are being seriously considered. The initial fund raising during CSM was very promising.

SUMMARY

The Orthopaedic Section membership and Board of Directors both expressed support for the Clinical Research Network during the recent CSM meeting. For the CRN to be successful, it will need support from its membership. Please be generous in your support of this important project when you are asked to contribute.

Questions about the CRN may be addressed to the Foundation for Physical Therapy at 800-875-1378 or through e-mail at foundation@apta.org.

Recipients of Foundation Grants Funded by the Orthopaedic Section

1999 Philip W. McClure, PHD, PT, OCS Beaver College "Physical Rehabilitation in Patients with Shoulder Impingement Syndrome"

2000 James J. Irrgang, PT, PhD University of Pittsburgh "Process of Care and Outcomes in the Physical Therapy Management of Musculoskeletal Disorders of the Knee"

2000 Timothy W. Flynn, PT, PhD, OCS, FAAOMPT U.S. Army-Baylor "Identification of Patients with Acute Low Back Pain who Respond Best to Sacroiliac Region Manipulation"

2000 Kathleen K. Mangione, PT, PhD, GCS* Beaver College "Physical Therapist Interventions to Optimize Physical Performance in Patients After Hip Fracture"

2001 Margaret L. Schenkman, PT, PhD University of Colorado "Recurrent Low Back Pain: A Randomized, Controlled Pilot Intervention Study"

*This grant was funded 50% by Orthopaedic Section and 50% by Geriatrics Section

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Nancy T. White, MS, PT, OCS is the former Vice President of the Orthopaedic Section and is a member of the Board of Trustees of the Foundation for Physical Therapy.

IN MEMORIAM

Mark Trimble, PT, PhD, OCS died 2/10/01 at the University of Florida Shands Hospital. Mark was 42 years old and an assistant professor in the physical therapy program of the College of Health Professions at the University of Florida. He received his PT degree from the University of Evansville in Indiana, his master's degree from the University of Arizona, and his PhD in human performance and neuroscience from Indiana University.

Dr. Trimble's death is a loss to the specialty of orthopaedic physical therapy. His enthusiasm for and love of orthopaedic research and teaching was obvious. Mark's involvement with the Orthopaedic Section, APTA, Inc. included membership on the Awards Committee, moderating research platforms, presenting at the Combined Sections Meeting, and participating as an item writer for the orthopaedic specialty exam.

Mark is survived by his wife, Shelley Trimble; a daughter, Jessica (13); a son, William (7); his parents, William and Barbara Trimble of Middletown, Ohio; and two sisters, Robyn Trimble of Ohio and Kristin Wiseman of Arizona.

A scholarship fund has been established in his honor. Donations may be made to The University of Florida Foundation, Mark H. Trimble Scholarship Fund, Physical Therapy Department, Box 100154, University of Florida, Gainesville, FL 32610.

Practice Affairs Corner

Coordinated by Steve McDavitt, PT, MS

This "Practice Affairs Corner" contains 2 articles, both opinion pieces provided by our readers. The first relates to continuing professional education and the second to nontraditional roles for the physical therapist assistant. The authors hope to stimulate dialogue and we look forward to hearing your comments about both of these issues.

Selling Out Continuing Education

Richard L Smith, PT, MS, OCS and Ellen Hillegass, PT, PhD, CCS

INTRODUCTION: CONTINUING EDUCATION IN THE PAST

Ten years ago, athletic trainers and personal trainers were paraprofessionals we (the authors) didn't have much of an opinion about. They worked in clubs and schools, and generally dealt with the healthy population and student athletes. We attended continuing educational programs, which were taught by expert physical therapists with credentials of PT, but also ATC, Masters and Doctorates of various types, who came from a melting pot of backgrounds, and taught courses to mixed audiences. We didn't think it mattered that our programs were open to occupational therapists to learn about physical agent modalities, open to trainers to learn about closed kinetic chain programs, and open to exercise physiologists to learn about stress testing. We even went back to our clinics and shared our new knowledge with paraprofessionals such as trainers, aides, massage therapists, and occasionally, chiropractors and nurses.

EXERCISE PHYSIOLOGISTS AND LESSONS LEARNED

Physical therapists who have been working in the field of cardiovascular and pulmonary rehabilitation have been confronted with the issue of nonlicensed individuals, including exercise physiologists, who have been treating patients/clients with cardiovascular disease for many years. Although these individuals are not licensed, they have been treating patients mostly on an outpatient basis in programs often supervised by physicians and/or nurses. Most of these individuals have Masters degrees, and many have certifications through the American College of Sports Medicine, including Exercise Specialist and/or Program Director. Although exercise science programs vary across the country and are not accredited, many of these individuals have a strong background in principles of exercise prescription for the healthy client and for the patients with cardiovascular disease. Over the past decade, as more patients with cardiovascular disease have developed comorbidities such as pulmonary disease, renal dysfunction, musculoskeletal dysfunction and diabetes, exercise physiologists have been exposed to working with patients who have medical problems other than just their cardiovascular disease. While cardiovascular and pulmonary physical therapists were mastering the elements of patient/client management for this population, detailed in the *Guide to Physical Therapist Practice*, the exercise physiologist was right behind the physical therapist, learning, studying and practicing. In essence, the physiologist moved from an exercise model, to a medical model of practice. The ACSM developed a new certification for this group, the ACSM Registry for Clinical Exercise Physiologists. A year ago, approximately 125 individuals passed the first RCEP Registry examination.

BODY OF KNOWLEDGE

About the same time, the APTA House of Delegates debated whether to define our profession's body of knowledge, and chose not to. We also witnessed the debate whether to, or how to, confront the growing tide of paraprofessionals, the "wannabes," who seemed to be developing national agendas, agendas to be the practitioners of choice in their respective areas. Many leaders expressed the sentiment that we needed to focus on tooting our own horn, marketing our own expertise, and not to worry about the competition.

SCOPE OF PRACTICE

Fast forward to the present. The *Guide to Physical Therapist Practice*, among other APTA policy documents, defines the scope of physical therapy practice. Physical therapists are the only professionals who provide physical therapy. Physical therapist assistants—under the direction and supervision of the physical therapist—are the only paraprofessionals who assist in the provision of physical therapy interventions. Physical therapists provide services to patients/clients who have impairments, functional limitations, disabilities, or changes in physical function and health status resulting from injury, disease, or other causes.

SELLING OUT CONTINUING EDUCATION

Our opinion about training the paraprofessionals has changed recently. A growing number of continuing educational courses, taught by physical therapists, are including these groups in its target audience. Entrepreneurial Board Certified Physical Therapy Specialists are offering seminars to athletic trainers, strength & conditioning coaches, occupational therapists, and personal trainers. The 2001 IDEA Personal Trainer International Summit in New York City in February included programs taught by physical therapists: "the shoulder: hands-on scapular stabilization techniques, rotator cuff strengthening exercises and evaluation/testing procedures," "analysis of human gait in individuals with orthopedic injury: how to conduct a detailed examination and intervention based on evaluation findings," "just how functional are functional exercises," and "postrehabilitation for common orthopedic injuries."

The more we have looked at seminar advertisements, the more we have found programs offered to paraprofessionals who are unqualified, and often, unlicensed, to provide the interventions taught. But more and more, piece-by-piece, they are taking the body of physical therapy knowledge and applying it to their respective programming and business tactics. Who can blame them? Evidently, there is a market for these providers. It really sunk home when we recently found the certification possibilities on a misleading web site called PTontheNet.com, which by the way is not an abbreviation for Physical Therapy. Here you will see how to become a Certified Personal Trainer (CPT), an Integrated Manual Therapist (IMT), a Corrective Exercise Specialist (CES), or a Performance Enhancement Specialist (PES). A

Personal Trainer won recognition for his evaluation and treatment of a client with whiplash, based on the work of Travell, Kendall, Cyriax, Janda, etc. These nonlicensed individuals are learning "kinetic chain assessment, functional and biomechanical anatomy, motor learning, core stabilization, neuromuscular stabilization, functional strength, etc."

OUR SUGGESTION

In our opinion, the physical therapists teaching these paraprofessionals are selling out. To give up our body of knowledge, with callous disregard for the larger issues of what this crass gesture implies, can only point to one explanation: the sale of courses, and the money it brings. We urge all physical therapists to boycott these programs. We urge all components to immediately withhold sponsorship of the courses, or offering CEUs for them. And we urge the APTA leadership and House of Delegates to enter into a dialogue on the issue, and come up with a position to prevent the loss of our body of knowledge to these paraprofessionals.

Richard Smith, PT, MS, OCS is President of the Montana Chapter APTA, and Ellen Hillegass, PT, PhD, CCS is Vice President and Practice Chair of the Cardiovascular and Pulmonary Section, APTA.

There Is Demand for PTAs - Both Clinical and Nonclinical

Brad Thuringer, PTA, BS

Significant attention has been focused lately on the issue of the supply and demand of PTAs. Recent years have seen dramatic growth in the number of PTA educational programs, significant expansion of the number of practicing PTAs, and concern about whether or not we are producing too many PTAs for the market to bear.

The factors surrounding the workforce issues of the PTA are too complex and detailed for the purpose of this article. Many of the factors that affect the supply and demand of PTAs are beyond the control of the physical therapy profession and of individual PTAs. What I would like to discuss are the aspects of supply and demand that WE can affect. I feel the time is right to begin thinking of significant expansion of "nonclinical" roles for the PTA.

Who in the late 1960s could have accurately envisioned the current clinical deployment of practicing PTAs? What will the clinical demographics look like 30 years from now?

One area that we as PTAs have not explored much is the role of the nonclinical PTA. While we need to be ever vigilant in expanding clinical opportunities, we need to simultaneously explore new opportunities for the PTA in every level of government, health care administration, research, etc. It is critical to the long-term survival and success of PTAs that we begin deploying PTAs beyond the direct health care setting in as many "nontraditional" roles as our collective imaginations can dream up.

The key to survival in a policy-driven health care world is to become an integral part of the policy making machine. PTAs are often victims of policies, regulations, and laws. Despite our dramatic growth and success in the profession in the last 32 years, we are still young and small in relative numbers. We as PTAs do not have the same political clout as PTs, ATCs, and Chiropractors at both the national and political level. This limits the PTA and the potential we have in the profession.

There are PTAs who work in the administrative world, but how many of them retain their identity as PTAs? Physical therapists, physicians, and nurses nearly always keep their professional identities as they assume nonclinical roles in government and organizations. We need to foster the same professional climate as our PT colleagues as we mature in the profession.

We need a dramatic expansion of research into the clinical deployment of PTAs, as well as a culture that values PTAs who chose to complete graduate degrees in research, administration, business, policy, academics, etc. In a perfect world, these PTAs should be educated in PTA-run institutes of higher learning.

As long as there are medically underserved areas and PTs practicing without PTAs, we haven't come close to exhausting the demand for the clinical PTA.

I also believe that the best advertisement for the profession of physical therapy and the role of the PTA is competent, skilled, and caring PTs and PTAs.

We need to expand existing markets for PTAs, and value nontraditional roles for PTAs. To this end, we need to focus more on the quality of the PTA we train, not the numbers. We need to better "sell" unity of the profession to all who have not heard the message. And we need to begin actively deploying the next generation of PTAs into policy setting and policy making roles for the future.

Properly educated PTAs are uniquely qualified to serve in policy roles with organizations and government. This will become ever more important in an increasingly hostile and uncertain health care environment. This nontraditional deployment of PTAs is critical to our long-term survival and effectiveness. As long as PTAs honor their history and genesis and continue to serve the profession and health care needs of the patients who give purpose to their lives, the future is very bright!

I invite you to join me and the many other PTAs in the National Assembly, who love what we do and are working towards the future. Then, and only then, can we formulate our strategies to reach our goals.

Brad Thuringer, PTA, BS is Vice Presiding Officer of the National Assembly.

The Real Needs of the Patient with an Orthopaedic Condition

Steven G. Lesh, PT, PhD, MPA, SCS, ATC

This column is geared toward the physical therapist assistant and is being coordinated by Gary Shankman, PTA, MS, OPAC, ATC, CSCS.

Recent trends in scholarly writing have supported the important clinical practice of promoting people-first language.[1] By using people-first language, the strategic purpose is to not supplant a personal subject with a disability or medical condition. The focus of the sentence structure should be on the client or patient as an individual followed by appropriate modifiers describing the condition of the person. Indeed, from a dignity perspective, it is a patient with a spinal cord injury and not a spinal cord injury! Many clinicians can remember or appreciate the urgent calls from the nurses station that the "total hip in room 204 needs to go to the bathroom." The vision of a hip prosthetic appliance going to the bathroom is humorous, and is clearly not what is intended by the comment. The utilization of nonpeople-first language can promote biasing or discrimination, and certainly does not promote a warm patient friendly health care environment. Imagine yourself as the son or daughter of the elderly lady in room 204 who urgently needs to go to the bathroom. As part of the orthopaedic rehabilitation team, the physical therapist assistant plays a critical role in the delivery of services, and is on the front line of interaction with the patient. Promoting a people-first approach not only encourages a more respectful and dignifying interaction, but also helps to lessen the institutionalization of the health care system. The purpose of this brief paper is to address the real needs of patients with orthopaedic conditions and to promote an atmosphere of dignity and respect when working with this population.

Every physical therapy clinician has felt at one time or another pressures to meet deadlines or complete intensive workloads. It is easy in a hectic paced atmosphere to simply complete the prescribed treatment plan and quickly move on to the next pending case. As the process moves forward, the treatments soon are not directed at the promotion of lost function for the patient, but rather are protocols based on orthopaedic diagnoses. The individual patients are forced into an institutional process. Their individual needs are often placed second to the needs of the organization, the rehabilitation department, or the individual therapist. The following case is presented to support the need for promoting the people-first environment and addressing the needs of the individual patient first and the needs of the system second.

R.S., an 86-year-old man, recently underwent an open reduction, internal fixation (ORIF) of his left hip and splinting for a compacted fracture of his left distal radius sustained in a fall as he was getting out of his car on a rainy afternoon. He had been in generally good health, but had progressive peripheral neuropathies of unknown etiology that began to rob him of his balance and lower extremity coordination. His rehabilitation course was prefaced by the orthopaedic surgeon who told his family, "His bones are strong and he will heal quickly." After spending 3 weeks in an acute care setting followed by 6 weeks in a rehabilitation setting, R.S. became increasingly depressed and was slow to recover. The orthopaedic surgeon could not explain the slow results in simple orthopaedic terms, even though the surgery and bones were healing well.

From the point of view of the orthopaedic surgeon, R.S. had a simple "broken hip and wrist," but in the view of R.S., his hip hurt, and he had to use a walker. He was also losing his independence, his home, the ability to drive, and he was outliving most of his friends and peer support groups. Several of R.S.'s friends had physical therapy during their hospitalizations, not long after which, his friends died. Rehabilitation was not viewed by R.S. as an opportunity to improve, but as a messenger of death. In this scenario, "a simple broken wrist and hip" should have been easily overcome in the eyes of a younger individual, but in the eyes of an aging individual, this same scenario was a precursor to losing overall independence.[2]

It is critical that the physical therapist assistant understands and appreciates the needs of the patient during the rehabilitation process. Many factors, both socioeconomic and psychosocial, will impact the needs of the patient with an orthopaedic condition. The presence of these factors may enhance or distract from the rehabilitation process, limiting the ability to place every patient into a nice and neat protocol box. From a dignity perspective, the physical therapy profession owes a greater respect for the individuals that are entrusted to its restorative services.

Paradigm shifts have changed the face of health care in the 21st century. Forces have pushed the system from paying bills to buying value, from sickness to an emphasis on health, and from shifting responsibility to taking responsibility.[3] The physical therapist assistant can promote the needs of the patient during these paradigm shifts by encouraging active participation of the patient instead of the more traditional passive participation. Methods should be explored so that the patient can alleviate his or her own pain instead of encouraging dependancy on passive modalities and third person intervention. Encourage opportunities for the patient to express his or her concerns about the course of the treatment instead of telling the patient what is normal and expected for his or her given orthopaedic condition. The physical therapist assistant should work with the patient to actively demonstrate their home program instead of simply handing the patient a sheet and instructing them to work on these exercises at home. Lastly, and possibly most importantly, the PTA should strive to educate and empower the patient regarding the medical system instead of funneling the patient passively along standard channels.[2]

Superficially, the needs of the individual client may incorporate impairments and functional limitations associated with his or her orthopaedic condition. Certainly, as rehabilitation experts, the physical therapy profession most frequently is utilized to overcome or manage these impairments and limitations. However, the real needs of the patient are often deeper and more complex. The parents of the child born with club feet are horrified to think of whether or not their child will be normal. The high school football player who suffers an anterior cruciate ligament injury is fo-

(Continued on page 19)

Book Reviews

Coordinated by Michael J. Wooden, PT, MS, OCS

Bukowski E. *Muscular Analysis of Everyday Activities.* Thorofare, NJ: SLACK, Inc.; 2000, 266 pp., illus.

To "facilitate observational and objective analysis of performance" is the author's stated purpose in this text and its accompanying *Instructor's Manual*. Written from a basis in academia, the book thoroughly explores the details required to measure joint angulation and muscular factors in accomplishing daily tasks such as donning a sock, shaving the face, propelling a wheel chair, or lifting a package from the trunk of a car.

Divided into chapters addressing a specific skill, the book describes anatomical placement of measurement devices, describes sequential phases of critical motions, addresses clinical applications, and stimulates the student to discover alternative approaches. The *Instructors Manual* contains a step-by-step approach to teaching the methodology of critical analysis to a student population. The book's direct application to a clinical population with functional deficits is best noted in "Appendix A", a complete chart of prime movers and possible substitutes.

This book will find a good home among researchers who strive to assist rehabilitation professionals in defining functional deficits and demonstrating the value of rehabilitation through related outcome studies.

Jill Floberg, PT

Carr J, Shepherd R. *Movement Science: Foundations for Physical Therapy in Rehabilitation*. 2nd ed. Gaithersburg, MD: Aspen Publishers, Inc.; 2000, 220 pp., illus.

This is the second edition of a book that was originally published in 1987. As mentioned in the preface, this book presents an argument to the neurologic rehabilitation community for the relevance of scientific findings related to human movement. The editors note that this edition provides new experimental findings in science, as well as clinical practice.

The textbook is divided into 4 chapters. The first chapter is comprised of a well-written historical perspective on neurological rehabilitation. The author provides a critical evaluation of the theoretical assumptions underlying different treatment approaches, as well as a section that discusses the Nagi model of disablement and how it applies to clinical practice.

The second chapter provides a theoretical framework for rehabilitation in the context of the movement dysfunction that results from an acute brain lesion, such as stroke. A strong emphasis is placed on skill acquisition and motor performance. There are also sections that describe the impairments underlying functional disabilities and the effect that the rehabilitation environment may have on the patient. Practical examples are routinely provided in this chapter, which allow for easy application to the clinical setting. The chapter is also well illustrated with quality photographs and line drawings that support the text.

The third chapter discusses the processes underlying skill learning with implications for clinical practice. An analysis of functional tasks is presented based upon their environmental context and functional role, as well as a discussion of the processes involved with skill acquisition.

The fourth chapter discusses recovery of function after brain damage, including the response of the central nervous system to damage, pharmacology, factors influencing recovery, and implications for therapeutic interventions.

The authors have presented an approach to neurologic rehabilitation that is based upon movement science theory and research, as well as clinical evidence. This book is very well written and up to date on the latest research, with extensive reference lists provided. This book is highly recommended for clinicians who treat patients with neurological disorders. I also recommend this book for physical therapist students, especially those who will work in neurologic rehabilitation environments. Finally, I believe this book can be useful for orthopedic physical therapists, as many of the movement theories and research findings discussed can be useful in evaluating and treating patients with orthopaedic disorders.

Michael D. Ross, PT, DPT, OCS

Rucker KS, Cole AJ, Weinstein SM. *Low Back Pain: A Symptom-Based Approach to Diagnosis and Treatment*. Boston, Mass: Butterworth-Heinemann; 2001, 394 pp., illus.

This text covers the assessment, management, and treatment of patients presenting with low back pain with or without leg symptoms. There are also reviews of electrodiagnostics, radiological investigations, medications, and a section dedicated to low back pain and disability.

There are 4 sections in the book. In the first section, adolescent, adult, and geriatric spine disorders are covered in separate chapters. Each chapter presents specific information relating to more serious pathology, ie, tumors, as well as spinal pathology unique to each age group.

Assessment of low back pain is the focus of the next section, which contains 3 chapters. The chapter on biomechanical assessment of low back pain concentrated on the actual physical examination process. Tests were included for differential evaluation of the hip and sacroiliac joints. The muscular system also was addressed to assess its ability to stabilize the spine and as a producer of symptoms. Radiographic evaluation was explored in detail in the next chapter. The indications for each test were given as well as the test's reliability and sensitivity. This chapter was clearly illustrated with examples of the various imaging techniques. The last chapter, Electrodiagnosis of Lumbosacral Radiculopathy, included numerous case studies that highlighted the use of electrodiagnostic testing to form the diagnosis.

The use of medications, physical therapy, injections, and surgery comprised the next section, which concentrated on management and treatment. The chapter on medication initially presented a brief review of acute and chronic pain. The various categories of medications were listed along with the rationale for their use, contraindications, and typical and maximal dosages. The chapter concerning physical therapy emphasized the importance of the patient's clinical presentation rather than his/her diagnosis in guiding treatment. The rationale for

treating the joints and soft tissue were explained clearly and examples of sample treatments for various clinical presentations were presented. Injection therapy was discussed in the following chapter. The technique, medication type, and patient selection process were reviewed. It was stressed that the main benefits of injections were to aid in the diagnosis and provide periods of decreased symptoms to allow the rehabilitation process to be completed. The various surgical options were discussed in the next chapter. Percutaneous and open techniques were described along with various outcome studies for each procedure. The appropriateness of spinal fusion for the treatment of chronic discogenic low back pain was entertained.

The last section covered low back pain and disability. Risk factors in the development of acute and chronic low back pain were presented in detail. Methods to determine these risk levels were discussed. Industrial low back pain was the topic of the next chapter. Various case studies illustrated the different levels of complexities with which these patients presented. Functional performance evaluations were the focus of the next chapter. These evaluations were described along with factors that affect outcome. The current literature was reviewed to assess the evaluation's reliability. The next chapter, Assessment and Treatment of Chronic Low Back Pain: The Multidisciplinary Approach, discussed the use of multidisciplinary pain centers. The last chapter in the book examined the medicolegal issues involved with both acute and chronic low back pain. These topics included personal injury cases, workman's compensation, and disability.

Overall the book was well written with clear and explicit illustrations. The text flowed evenly from chapter to chapter, which can be difficult when there are multiple authors involved. Attempts were made to include current outcome data. I would recommend this book for any physical therapist whose practice is focused on low back pain.

Jeff Yaver, PT

Lusardi MM, Nielsen CC. *Orthotics and Prosthetics in Rehabilitation.* Boston, Mass: Butterworth Heinemann; 2000, 612 pp.

The authors aim to compile a book "to enable aspiring students and practicing clinicians to determine and implement the approach that is most appropriate for each patient who might require an orthosis or prosthesis." To accomplish this successfully, 36 clinicians including OTs, PTs, CPOs, and biomechanical engineers presented their areas of expertise. The book is divided logically into 3 main sections. Section 1 is entitled, Building Baseline Knowledge. Section 2 covers Orthotics and Section 3 presents Prosthetics. A total of 31 chapters make up this text.

In the first section of this book, the authors do a superb job laying the foundation for the forthcoming chapters. They do a great job of not assuming the knowledge base of the reader. Ample use of pictures, drawings, and graphs facilitate the learning process. I found Chapters 3, and 4 especially helpful in providing excellent information especially Chapter 3, which provides a superb assessment of a normal gait cycle. By knowing this, the clinician is able to recognize abnormalities in patients that may need orthotics. In Chapter 4, critical information was given involving the efficiency of gait, the energy cost for patients who may be older or deconditioned, and the affect that orthotics may have on these types of patients.

Section 2 includes a total of 14 chapters that provide coverage of Orthotics in Rehabilitation. In Chapter 5, Principles of Orthotic Design, the author does a particularly thorough job explaining some basic kinesiologic principles as they apply to joints during movement and to the design of the orthoses. The chapter will help the clinician involved in foot and/or ankle orthoses by helping them see important biomechanical factors that must be assessed before deciding on orthotics. In Chapters 6 through 9, the need for further orthotics in the lower extremities is presented. Chapter 7 presents extremely useful information to the reader as the author gives a baseline of shoe characteristics and modifications for certain types of deformities to aid the clinician in this process. The use of orthotics from the knee and upward to the hip is given in clear and sufficient detail in Chapter 9. The management of scoliosis through exercise and orthotics is covered in Chapter 15. The last 3 chapters of this section provide excellent information for the clinician specifically principles of splinting and casting in patients with burns and fractures.

In the last section (which is made of 13 chapters), the use of prosthetics is covered in good detail. The authors emphasize the necessity of prevention, especially with the high-risk patient. When amputation is required, the authors provide essential information needed for postsurgical management. In the last 2 chapters, the authors cover rehabilitation for children with limb deficiencies and also upper extremity amputations.

I found this book, *Orthotics and Prosthetics in Rehabilitation,* relevant, very complete, well ordered, and well referenced. The authors have successfully compiled an enormous amount of technical information into a usable, excellent text. They have accomplished their goal to provide a text and reference for both the student and the clinician to facilitate decision making with their own patients. This text would be especially appropriate for PTs, OTs, CPOs, and DOs.

Dan Bankson, MSPT, CSCS

(Continued from page 17)

cused on how soon he can get back into the game. The father of a family of 4 is worried about providing for his wife and children after he injured his back at work. The elderly lady who falls at the local grocery store and suffers a fractured proximal femur is fearful of losing her independence. Each patient that attends a physical therapy session has individual needs that are primary and paramount to his or her respective recovery.[4] As the orthopaedic rehabilitation team strives to put the patient first in both language and needs, the health care system will continue to improve and enhance the respect and dignity given to those seeking our special skills and knowledge.

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Orthopaedic Section, APTA, Inc.

CSM Board of Directors Meeting
February 16, 2001 • San Antonio, TX

MINUTES

The 2001 CSM Board of Directors Meeting was called to order in San Antonio, TX at 8:30 AM on Friday, February 16, 2001 by Bill Boissonnault, President.

ROLL CALL:
Present:
Bill Boissonnault, President
Nancy White, Vice President
Ann Grove, Treasurer
Joe Farrell, Director
Gary Smith, Director
Michael Wooden, Membership Chair
Lola Rosenbaum, Education Chair
Paul Howard, Education Vice Chair
Susan Appling, OP Editor
Phil McClure, Research Chair
Michael Cibulka, Specialization Chair
Steve McDavitt, Practice Co-Chair
Carolyn Wadsworth, HSC Editor
Terry Randall, Public Relations Chair
Mary Ann Wilmarth, Nominating Chair
Tom McPoil, FASIG President
Jennifer Gamboa, PASIG President
Tom Watson, PMSIG President
Debra Lechner, OHSIG President
Cheryl Riegger-Krugh, APT SIG President

Randy Roesch, APTA Liaison
Terri DeFlorian, Executive Director
Tara Fredrickson, Executive Associate
Absent: None

MEETING SUMMARY:

The agenda for the 2001 CSM Board of Directors Meeting was approved as printed.

The minutes from the 2000 Fall Board of Directors Meeting in La Crosse, WI were approved with changes.

ACTION ITEMS:

=MOTION 1= The Orthopaedic Section discontinue its student guest program at CSM and replace it by sponsoring a student to the annual Student Conclave.=PASSED=

Fiscal Implication: $1,055

=MOTION 2= Beginning in 2002 the Finance Committee Meeting (August) will be flip-flopped with the Fall Board Meeting (October). =PASSED=

Fiscal Implication: None

=MOTION 3=The Orthopaedic Section provide a letter of request to participate with St. Luke's Rehabilitation Institute for the development of a Telehealth Connection and the support of Rural Education and Distance Learning.=PASSED=

Fiscal Implication: None

=MOTION 4=The Primary Care Educational Group will be established by the Orthopaedic Section for 2002 CSM.=PASSED

Fiscal Implication: None

=MOTION 5=The Orthopaedic Section will fund the best qualified person to attend the AAOS Hip Fracture Conference in 2001. The individual does not have to be an Orthopaedic Section member. The Research Committee is charged with finding this person. =PASSED=

Fiscal Implication: $860

=MOTION 6=The following bonus' will be given to each employee during the year they celebrate their anniversary:

5 year	$500
10 year	$1,000
15 year	$2,000
20 year	$5,000

=PASSED=

Fiscal Implication: Amounts listed above will be given if funds are available.

=MOTION 7=Investigate the Section working with APTA on developing 1 to 5, 2-hour educational web-based courses. Proposal to be brought back to the Board at Annual Conference 2001.=PASSED=

Fiscal Implication: None

=MOTION 8=Allocate up to $5,000 for development of a movie/mini CD to be used on the website, presentations, and through press releases. Proposals are due by the Annual Conference Board Meeting in June 2001.=PASSED=

Fiscal Implication: Up to $5,000

=MOTION 9=Restore OHSIG budget to $15,000 annually.=FAILED=

Fiscal Implication: None

=MOTION 10=Request funding for past Animal Physical Therapist SIG president, Lin McGonagle, for orientation and mailing of materials to new SIG president. =PASSED=

Fiscal Implication: $149.22

POLICIES:

1) Research grants are currently funded for two at $5,000 and two at $10,000 for a total of $30,000. The Board agreed to give the Research Committee flexibility in allocating the funds as they deem appropriate.

Adjournment 7:30 PM

Section Member in the News

Congratulations to Jay Lamble, PT, MS, NCS, OCS, MTC and Maureen Raffensperger, PT, MS, OCS. They each won a free webcast (an APTA on-line continuing education course) during the webcast demonstration APTA had in the Cyber Cafe at CSM. One name was picked each day - Thursday through Saturday - and they were two of the lucky winners!

CSM 2001 Business Meeting Minutes
February 17, 2001 • San Antonio, TX

I. CALL TO ORDER AND WELCOME – President, Bill Boissonnault, PT, MS, DPT

Nylanne Little, Registered Parliamentarian, was the parliamentarian for the meeting.

II. BOARD OF DIRECTOR REPORTS

A. President – Bill Boissonnault, PT, MS, DPT

=MOTION 1=Approve the agenda as printed.=ADOPTED=

=MOTION 2=Approve the business meeting minutes from CSM in New Orleans, Louisiana February 5, 2000 as printed in Volume 12:1:00 issue of *Orthopaedic Physical Therapy Practice*.=ADOPTED=

1. Announcements
   a. A call for applicants for the HSC Editor position has been published. The deadline for receipt of applications is Monday, February 26, 2001.
   b. A call for applicants for the JOSPT Editor-in-Chief position has been published. The deadline for receipt of applicants is April 15, 2001.
   c. APTA Department of Minority/International Affairs has established the Diversity 2000 Capital Campaign as an endowment for their organization. The Orthopaedic Section has been a strong supporter of this for a long time. In the past the Section gave $8,000 - $10,000 annually and over the last 4-5 years has contributed by purchasing a table at the annual Diversity 2000 fundraiser event. The Section decided that it needed to do more so at the end of 2000 they contributed $5,000 and also earmarked 25% of the profits from the Section's pediatric home study course for this cause. At the end of CSM the Section will be sending $25,000 to the Diversity 2000 Capital Campaign.
   d. The Section has budgeted $10,000 in 2001 to support the development of clinical residency and fellowship programs. This grant money is to fund the application fee to go through the APTA process. The Section has had 6 or 7 groups take advantage of this over the past 2 years.

B. Vice President – Nancy White, PT, MS, OCS

1. Nancy is the Section Awards Committee Chair and is also on the Foundation's Board of Trustees.
2. Nancy thanked the membership for the opportunity to serve as the Vice President over the last 6 years. She also thanked the Section for the opportunity to serve on the Foundation Board of Trustees over the past 3 years.
3. All the Trustees are most proud of the growing record of the Foundation in terms of giving money for research and at the same time managing the finances responsibly. Three years ago the overhead of expenses to revenues was 128%. At this time the overhead is closer to 30% and is shrinking on a quarterly basis.
4. This is the last year of funding for the Clinical Research Center (CRC) through the Foundation. The Section has supplied about 50% of the funding for this over the last 3 years.
5. Recent recipients of the small grants the Section has funded through the Foundation are listed below. The wording of these grants has been to evaluate the effectiveness of physical therapist interventions with patients with musculoskeletal disorders. Chris Powers received an award in 2000 for, *Comparison of Spine Mobilization and Active Extension using Dynamic MRI*. Tim Flynn received an award in 2000 for, *Identification of Patients with Acute Low Back Pain who Respond Best to Sacroiliac Region Manipulation*. Phil McClure received an award in 1999 for *Physical Rehabilitation in Patients with Shoulder Impingment Syndromes*.
6. The Foundation made a formal request to the Orthopaedic Section Board of Directors for financial support for the new Clinical Research Network (CRN) which is like a super CRC. The Section Executive Committee will consider this request at their meeting immediately following the Business Meeting.
7. The two physical therapy student award winners were recognized, Mary Ellen Bulow and Olga Marie Gonzalas as well as Tim Flynn, this year's recipient of the James A. Gould, III Award for Excellence in Teaching Orthopaedic Physical Therapy.
8. The Awards Committee members were recognized and thanked for their contributions: Mari Bosworth, Cori Eastwood Boyd, and Mark Trimble. Mark passed away last week from an aneurysm, and the Section Board voted to donate a gift in his memory to the University of Florida.

C. Treasurer – Ann Grove, PT

1. Special thanks were given to the Finance Committee members: Joe Godges, Pam White, and Stuart Platt.
2. As of December 31, 2000 our annual budgeted income and annual actual income were pretty close. The Section brought in a little more income than what was budgeted due primarily to the home study courses.
3. As of December 31, 2000 our budgeted expenses were less than what was actually spent so the Section finished the year within budget.

D. Education – Lola Rosenbaum, PT, MHS, OCS

1. One change will be made next year at CSM. There will be a 2-hour session with several round tables set up, one for each education group and special interest group, all in the same room. Individuals can come and sit at a table of their choice to listen to and participate in issues being discussed.
2. Thank you to all who made this CSM possible:
   - Paul Howard - Education Vice Chair
   - Ray Vigil - Occupational Health SIG
   - Patty Zorn - Manual Therapy Education Group
   - Nick Quarrier - Performing Arts SIG
   - Mark Cornwall - Foot and Ankle SIG
   - Gary Shankman - Orthopaedic PTA Education Group
   - Joe Kleinkort - Pain Management SIG
   - Kristinn Heinrichs - Animal Physical Therapist SIG
   - Chris Powers - Patellofemoral Education Group
   - Stefanie Snyder - Program Coordinator at the Section office

E. Research – Philip McClure, PT, PhD

1. There was a tremendous response to the platforms again this year with an increase of 20% over last year. The quality, not just the quantity, goes up every year.
2. A small change was made in the small grant program for this year to reallocate the money so fewer grants will be given but each will be a larger dollar amount.

F. Practice – Steve McDavitt, PT, MS

1. This is a member driven committee and the committee works very hard to address the needs of members. If you believe there are concerns the committee is not addressing, please contact the committee.
2. Common language has now been developed with the terminology on mobilization and manipulation. This new language appears in the new *Guide to Physical Therapist Practice.*
3. The VA document has now been distributed from APTA and all the states have copies. This should help in defending manipulation and mobilization.
4. There is a practice corner in *Orthopaedic Physical Therapy Practice*. The areas covered are not just related to interaction, protection, and promotion but also research and clinical practice.
5. Special thanks to Bill and Nancy for all their support over the years.

III. COMMITTEE REPORTS

A. Membership – Michael Wooden, PT, MS, OCS

1. This committee is fairly new having formed last year at this time. There are about 14 or 15 members.
2. Membership growth last year was about 2%, which is the Section's goal.
4. The loss of PTAs and student members is of concern to the committee. A survey is being developed to try and find out the needs of these members.
5. Linda Calkins from the Section office was thanked for all her work with the Membership Committee.

B. OP Editor – Susan Appling, PT, MS, OCS

1. The Advisory Council was thanked; Phil McClure as Research Chair, Helene Fearon as Practice Co-Chair, Steve McDavitt as coordinator of the Practice Affairs Corner, Ann Grove as Board Liaison, Michael Wooden who coordinates abstracts and book reviews, Gary Shankman as the PTA member, Tom McPoil from the Foot and Ankle SIG, Tom Watson from the Pain Management SIG, Donna Ritter from the Performing Arts SIG, Arlene White from the Animal Physical Therapist SIG, and Michael House from the Occupational Health SIG.
2. Sharon Klinski was thanked for her work as Managing Editor.
3. OP is now referenced in the Cummulative Index of Nursing and Allied Health Literature (CINAHL).
4. Submissions are always encouraged from members. OP is not a peer-reviewed publication. Clinical articles are welcome.

C. Orthopaedic Specialty Council – Michael Cibulka, PT, MHS, OCS

1. The Council is redoing the DACP which is going to be renamed the DSP, Description of Specialized Practice. Surveys will be sent soon so hopefully the document will include *Guide* language, as well as evidenced-based medicine language. Jean Bryan has done the majority of this work.
2. Members of the committee were thanked, Nancy Henderson and Bob Johnson.
3. Members of the CCE (Committee of Content Exerts) were also thanked, Rob Landel and Sibrina Linscomb. The new incoming member will be Doug Kelsy.
4. The PDP (professional development portfolio) is being redone for those who want to recertify in Orthopaedic Physical Therapy. It will be made easier to read and easier to fill out.
5. Item writers are needed. This is a difficult process and interested persons are to contact Michael Cibulka.

D. Home Study Course Editor – Carolyn Wadsworth, PT, MS, CHT, OCS

1. In 2000 the Section published 4 home study courses. Registrations are at an all time high.
2. Courses that will be offered in 2001 are Solutions to Shoulder Disorders, which will run from January - June. Beginning in August is Current Concepts in Orthopaedic Physical Therapy. This will be a double course and very comprehensive covering all of the body regions and hopefully stimulate a lot of interest in specialization.
3. Courses for 2002 are already being planned. Prosthetics and Orthotics is one and Orthopaedic Interventions for Selected Disorders is the second. The authors have been secured and have begun writing.
4. Carolyn's term is up as HSC Editor this year. She will be working with the new Editor to hopefully ensure a smooth transition.
5. Home study course production has been moved back to La Crosse from Allen Press.
6. Thanks were given to the Section office staff—in particular Kathy Olson who is the HSC Coordinator and has done a marvelous job.

E. Public Relations – Terry Randall, PT, MS, OCS, ATC

1. Any ideas or thoughts of things that have worked in your practice or Chapter please let the Public Relations Committee know of them.
2. Thanks were given to the office staff for all their help and also the Public Relations Committee members—Mike Tollan, Pat Zerr, and Rick Watson.

F. Nominations – Mary Ann Wilmarth, PT, MS, OCS, MTC, Cert. MDT

1. The Nominating Committee is a great place to start if you are interested in getting involved with the Section. Please contact any member of the Committee.
2. The members on the Nominating Committee are Mary Milidonis, Bill O'Grady, and our newly elected member, Timothy Flynn. Mary will be the new Nominating Committee Chair commencing at the end of this Business Meeting.
3. The election results are: Michael Cibulka, President; Lola Rosenbaum, Vice President; and Timothy Flynn, Nominating Committee Member.
4. Next year we are looking to fill the positions of Director, Treasurer, and one other Nominating Committee Member.
5. =MOTION 3= To approve the nomination of Steve McDavitt for Director in the upcoming election.=ADOPTED=

G. JOSPT – Rick DiFabio, PT, PhD, Editor-in-Chief

1. Emily Petty, the new Assistant Editor for the Journal, was introduced.
2. When Rick began his term as JOSPT Editor-in-Chief the Journal was ranked 9 out of 11 in the field of rehabilitation by an external ranking

agency. Today the Journal is 4 out of 19. In the orthopaedic area, the Journal was ranked 21 out of 37 and today is ranked 11 out of 42.

3. Fewer articles are being published than in the past. In 1977, 78 articles were published. Last year only 63 were published. The impact ratings for those 63 articles are up dramatically. The acceptance rate is about 40% of articles received.
4. Proceedings from the Foot and Ankle SIG Conference on Diagnosis of Ankle and Foot Stability will be published for the first time in the history of the Journal in the March issue of JOSPT.
5. The Cervical Spine Special Issue Part 2 will come out in April 2001.
6. A special issue on the neuromotor control in the knee will come out in the Fall of 2001.

H. SPECIAL INTEREST GROUPS

Bill Boissonnault recognized the following individuals:

- Debrorah Lechner, President, Occupational Health SIG
- Tom McPoil, President, Foot and Ankle SIG (Steve Rieschl the incoming SIG President)
- Jennifer Gamboa, President, Performing Arts SIG
- Tom Watson, President, Pain Management SIG
- Cheryl Riegger-Krugh, President, Animal Physical Therapist SIG

IV. TASK FORCE REPORT

A task force was established last summer to develop a model curriculum for clinical residency programs. Carol Jo Tichenor volunteered to chair this task force. This was a joint effort between the Orthopaedic Section and AAOMPT. The document entitled, *Guidelines for Curriculum Development for Postprofessional Residencies in Orthopaedic Physical Therapy and Orthopaedic Manual Physical Therapy* is available for sale as of this meeting and can be obtained through the Orthopaedic Section. Members of the task force were recognized: Gail Deyle, Orthopaedic Section; Kathryn Lyons; Michael Miller, Orthopaedic Section; Stephania Bell, AAOMPT; Ann Porter-Hoke; Kornelia Kulig; Joe Godges, consultant; and Gail Jensen. Thanks go to Tara Fredrickson for all the minute-by-minute assistance and help in getting the final document ready for print in time for this meeting.

V. UNFINISHED BUSINESS

A. Director – Gary Smith, PT, PhD

1. Gary is liaison for the Education Committee, Research Committee, and Membership Committee.
2. =MOTION 1=The Orthopaedic Section will explore publishing consumer health information relative to common conditions treated by orthopaedic physical therapists on the Section web page.=ADOPTED=

Investigation into many more aspects have been pursued, one of which is telehealth, interactive learning through television. Utilizing the bulletin board on the Section's web site is also a way to communicate with colleagues. Tara Fredrickson at the Section office can be contacted if you would like to get information on the bulletin board.

3. All special interest group bylaws have been reviewed and updated so they are now consistent with the Section's bylaws.

C. Vice President – Nancy White, PT, MS, OCS

=MOTION 2=Charge the Awards Committee to explore the development of a new or existing award that would reward an individual for both research and service to the JOSPT and to report back at the next Board of Directors Meeting.=ADOPTED=

Mari Bosworth and Michael Cibulka were thanked for putting together some draft criteria for this award. The Board of Directors approved an award similar to this in concept and will be forwarded on to the Awards Committee for further refinement of the criteria and definition and purpose of this award. The difference in this award and the previous award that was in existence for only a very short time, is that this award recognizes an individual and not an article.

D. Practice – Steve McDavitt, PT, MS

=MOTION 3=The Section Board of Directors will explore physical therapists practicing in multiple jurisdictions within the United States and internationally and report back to the membership at CSM in 2001.=ADOPTED=

In investigating this motion it was found that each state has its own rules and regulations and each individual therapist needs to check with the state they will be practicing in. The Practice Committee is not satisfied with this so Steve will be contacting the Federation of State Boards to see if there is a way to start to deal with this issue.

E. Director – Joe Farrell, PT, MS

1. Joe thanked the following committee chairs who he is liaison for: Mike Cibulka, Specialty Council; Mary Ann Wilmarth, Nominating Committee; Steve McDavitt and Helene Fearon, Practice Committee; and Dorothy Santi, Section Historian.
2. Susan Appling and Sharon Klinski were thanked for their hard work on producing a monograph on the history of the Section, which we hope to have completed by Annual Conference in June.
3. Development of a position statement relating to clinical residency education/training. The APTA as well as the Education Section believe this is a worthy long-term professional goal which should be pursued within the Section. Joe will continue communicating with these groups as well as the Research Section and update the membership as new information is gathered.
4. =MOTION 4=The Section investigate and move toward trade marking/service marking the term "orthopaedic physical therapy."=ADOPTED=

In discussing this with Frank Mallon at APTA it appears that the term physical therapy cannot be trademarked. It is also unlikely that orthopaedic physical therapy could be trademarked because it is a very commonly used, general term. Joe has been advised that the title Orthopaedic Section, APTA, Inc. with our logo would be more likely to get approved by the patent and trade office. The cost per application to file for trade marking is $325. If the Section is to pursue this an attorney who specializes in trade marking should be hired to guide us through the process. The cost would be approximately $2,000.

Membership consensus was not to pursue any trade marking of Orthopaedic Section, APTA, Inc. or orthopaedic physical therapy or orthopedic physical therapy.

VI. NEW BUSINESS

A. Pam Duffy - Iowa

Position on Direct Interventions Exclusively Performed by Physical Therapists may be challenged at the upcoming House of Delegates in 2001. She encourages Section members to educate others at their state chapter meetings as to the importance of reinforcing the concepts of best practice and why this motion was passed in the first place.

Both sides of this argument were

published in past issues of OP along with the rationale for the motion and the outcome.

B. Tony Delitto

The Clinical Research Center (CRC) at the University of Pittsburgh officially ends March 31, 2001. They did a randomized trial in the area of work-related acute low back pain and determined that people were still better one year later. The paper has been submitted to a prestigious medical journal.Tony thanked the membership and the Orthopaedic Section for their contributions because without them this would not have been possible.

What do we do next? The Clinical Research Network (CRN) through the Foundation is the logical next step. The Research Section pledged $45,000 to the CRN.

=MOTION=The Orthopaedic Section will continue to financially support the Foundation for Physical Therapy and specifically the Clinical Research Network (CRN) to the best of its ability.=ADOPTED=

C. Bonnie Sussman – Vice President, OHSIG

The SIG has been working the last few years on publishing the compendium of guidelines of occupational physical therapy. Most of the document is APTA Board approved but the SIG is being asked by the APTA Department of Practice for support in publishing the compendium in written form so it is available to everyone. Please get any support information you have to Bonnie.

VII. PRESIDENT, BILL BOISSONNAULT, FAREWELL SPEECH

The last order of business today is for me to say thank you. This is the sixth and final Business Meeting I will be chairing as your President, and it has been a privilege to serve the Section in this capacity. I have been very fortunate during my 24-year physical therapy career, but without a doubt this has been the most rewarding professional experience I've had, and a tremendous personal experience as well. I thank you for that. It's the personal memories that I will treasure the most and that will stay the longest with me. I hope it's been obvious over the last 6 years that any successes we have had, have been the result of a group effort. Probably what I am most proud of, is the number of people who have made significant contributions to the Section over these 6 years. People I have been very privileged to have worked with and whom I will be forever indebted to are the officers I have served with, the office staff, committee chairs, committee members, the SIG presidents and officers, task force chairs like Carol Jo Tichenor, George Davies and Mark DeCarlo, presidents of the Sports Section, and Dr. Smidt and Dr. DiFabio, Editors-in-Chief of the JOSPT, and our APTA Board liaisons. My final request is that you continue to provide the same degree of support as you have the past 6 years. I believe if you do that, with the talent that we have on the Board under Mike's leadership, and the fact that we have all these resources there is no reason why this organization shouldn't continue to prosper and benefit all of us when we go back to our homes and become members again. It has truly been a privilege, and I thank you again.

ADJOURNMENT 10:30 AM

New Residency Curriculum Guidelines Form Template for Programs in All Specialty Areas

Are you looking for guidelines for starting a residency program? Are you considering entering a residency program?

The newly published document, **Guidelines for Postprofessional Residencies in Orthopaedic Physical Therapy and Orthopedic Manual Physical Therapy**, is now available for purchase. The American Academy of Orthopaedic Manual Physical Therapists (AAOMPT) and the Orthopaedic Section brought together residency directors, clinicians and educators from across the country to prepare this comprehensive resource document.

The document provides examples of part-time and full-time models for residency education in various health care settings. Recommendations on how to design the mission, philosophy, program goals and performance outcomes of a residency and how to integrate theoretical content with clinical course content are also described. Numerous examples are presented of instructional objectives, learning activities, methods for practical and written examinations and forms for program evaluation. Factors to consider in selecting and training faculty are discussed along with financial considerations for developing a residency budget.

The Guideline document is designed to assist residency programs applying for credentialing with the American Physical Therapy Association and/or recognition by the AAOMPT. **Because of the scope of the curriculum materials presented, the document provides outstanding resources for developing residencies in ALL specialty areas.** Individuals interested in residency education can use this information to evaluate current programs. Current programs can re-evaluate their curriculum for further growth.

Cost: $45 for Orthopaedic Section and AAOMPT Members; $65 for APTA Members; $80 for non-members
How to Obtain: The Orthopaedic Section will be handling all purchases.
Make check payable to: Orthopaedic Section, Inc. and mail to: 2920 East Avenue South, Ste. 200, La Crosse, WI, 54601-7202. Phone: 1-800-444-3982

Prepared by Carol Jo Tichenor, MA, PT

Current Concepts of Orthopedic Physical Therapy

Home Study Course 11.2
August–December 2001

HOME STUDY COURSE

An Independent Study Course Designed for Individual Continuing Education

Course Description

This course presents a thorough review of advanced concepts of the anatomy and biomechanics of each body region, application of specific tests and measurements, musculoskeletal pathology, and effective treatment strategies. Nationally and internationally recognized experts draw on their vast experience to share evidence-based techniques in Orthopedic Physical Therapy examination, evaluation, and intervention. Each monograph concludes with case scenarios that require clinical problem solving and allow you to compare your answers with the experts' rationale. Take advantage of this great opportunity to enhance your background and sharpen your reasoning skills.

Continuing Education Credit

Eighty-four contact hours will be awarded to registrants who successfully complete the final examination. Registrants must apply to their individual State Licensure Boards for approval of continuing education credit.

Topics & Authors

11.2.1 Connective Tissue Response to Injury, Immoblization, and Mobilization—*Varick L. Olson, PT, PhD*

11.2.2 Patient Examination—*Deborah Stetts, MPT, OCS*

11.2.3-4 Lumbopelvic Region (2 monographs)—*Peter Huijbregts, PT, MS, MHS, OCS, FAAOMPT*

11.2.5 Thoracic Spine and Ribcage—*Timothy W. Flynn, PT, PhD*

11.2.6 Shoulder—*Lori Thein Brody, PT, MS, SCS, ATC*

11.2.7 Elbow—*Jeff Ryan, PT, ATC*

11.2.8 Wrist & Hand—*Carolyn Wadsworth, PT, MS, OCS, CHT*

11.2.9 Cervical Spine—*Richard Walsh, PT, DHSc, OCS and Arthur Nitz, PT, PhD*

11.2.10 Hip—*Tim Fagerson, PT, MS*

11.2.11 Knee—*Bruce Greenfield, PT, MMSc, OCS; Brian Tovin, PT, MMSc, SCS, ATC, FAAOMPT; and Greg Bennett, PT, MS*

11.2.12 Foot & Ankle—*Susan Appling, PT, MS, OCS and Richard H. Kasser, PT, PhD*

Editorial Staff

Carolyn Wadsworth, PT, MS, OCS, CHT—Editor
Paul F. Beattie, PT, PhD, OCS—Spine Subject Matter Expert
Bruce Miller, PT, MS—Upper Extremity Subject Matter Expert
Lisabeth Kestel, PT, SCS, ATC—Lower Extremity Subject Matter Expert

Registration Fees*

Register by July 1, 2001. The first set of monographs is available in August 2001.
$200 Orthopaedic Section Members
$400 Non-Orthopaedic Section Members
Include $15.00 for shipping and handling.
WI residents add applicable state sales tax.

*If notification of cancellation is received in writing prior to the course, the registration fee will be refunded less a 20% administrative fee. Absolutely no refunds will be given after the start of the course. No multiple registrant discounts will be given for this course.

Additional Questions

Call toll free 877/766-3452 or visit our web site at: www.orthopt.org.

REGISTER ONLINE www.orthopt.org

APTA American Physical Therapy Association

11.2 Current Concepts of Orthopedic Physical Therapy

Name _____ Credentials (circle one) PT, PTA, other _____

Mailing Address _____ City _____ State _____ Zip _____

Daytime Telephone Number (_____)_____ APTA # _____ E-mail Address _____

For clarity, enclose a business card. Please make checks payable to: Orthopaedic Section, APTA

Please check:
☐ Orthopaedic Section Member
☐ APTA Member
☐ Non-APTA Member
(Wisconsin residents add applicable sales tax.)

I wish to join the Orthopaedic Section and take advantage of the membership rate. (Note: must already be a member of APTA.)
☐ I wish to become a PTA Member ($30).
☐ I wish to become a PT Member ($50).

Mail check and registration to: Orthopaedic Section, APTA
2920 East Avenue South, Suite 200, La Crosse, WI 54601 Toll Free 877-766-3452
OP

Fax registration and Visa or MasterCard number to: (608) 788-3965

Visa/MC (circle one)#_____

Expiration Date_____ Amount_____

Signature _____

2001 CSM Award Winners

Outstanding Physical Therapy Student Award

(Left to Right) Olga Maria Gonzolez; Nancy White, Awards Chair; and Mary Ellen Bulow.

The purpose of the Outstanding PT Student Award is to identify a student physical therapist with exceptional scholastic ability and potential for contribution to orthopaedic physical therapy and to provide the means for this student to attend and participate in a national meeting. This year, there are two recipients of this award.

Mary Ellen Bulow completed her Master of Physical Therapy degree at Northwestern University in November 2000. She was nominated by her clinical instructor who was impressed by her outstanding clinical competence, her exceptional reasoning skills, and her strong ability to communicate with others. Mary Ellen is known for her professionalism and commitment to membership in the APTA. She has presented her research in the area of spine proprioception at the Illinois Physical Therapy Association meeting and at CSM 2001. Her potential to contribute to orthopaedic physical therapy and to the Orthopaedic Section is tremendous.

Olga Maria Gonzalez is a student in the Physical Therapy Program at Florida International University. She is perhaps best known among her friends and colleagues for her extensive volunteer work. Olga has participated in free gait training clinics for elderly citizens, volunteers regularly for her church, and has assisted with University sponsored workshops for the Shriner's Hospital. She is regarded as an excellent student who regularly takes extra time to help classmates with difficult material. She has a special interest in pediatric orthopaedics and should make many contributions to the field of orthopaedic physical therapy during her career.

James A. Gould Excellence in Teaching - Orthopaedic Physical Therapy Award

Tim Flynn

The purpose of this award is to recognize and support excellence in instruction of orthopaedic physical therapy principles and techniques through the acknowledgment of an individual with exemplary teaching skills.

Timothy W. Flynn, PT, PhD, OCS, FAAOMPT, Lieutenant Colonel, Army Medical Specialist Corps, is the 2001 recipient of the James A Gould III Excellence in Teaching of Orthopaedic Physical Therapy Award. Dr. Flynn is Assistant Program Director, Director of Research, and Associate Professor at the U.S.Army-Baylor University Graduate Program in Physical Therapy. He is also a faculty member and resident supervisor at the U.S.Army Orthopaedic Physical Therapy Residency and serves as a faculty member at Michigan State University's Continuing Medical Education program. He is the author of a highly regarded book on the evaluation and treatment of thoracic dysfunction and has published extensively in peer-reviewed professional journals.

Dr. Flynn is well known for his dedication to teaching evidence-based orthopaedic physical therapy. His students are consistently praised for their ability to provide literature-based care for their patients. His residents have performed such clinically relevant research that their findings have changed military physical therapy practice and impacted military physical training. Dr. Flynn is the clinical instructor most in demand by the residents in the US Army Orthopaedic Physical Therapy Residency. His style is both relaxed and stimulating, and his dedication to the profession along with his consistent contributions to research throughout his career are highly motivating for students.

Dr. Flynn has been a leader in utilizing technology and distance learning in his teaching. He is famous with his students for creating and using interactive CDs as adjuncts to his teaching. His lab courses are well known for their creativity and utilization of audiovisual technology.

Dr. Flynn's colleagues praise him as one of the country's most competent and capable teachers of orthopaedic physical therapy. The Orthopaedic Section is pleased to honor Dr. Flynn with this award.

Rose Excellence in Research Award

Gail Deyle is shown above with his authors.

Gail Deyle, MPT, OCS, FAAOMPT is the recipient of the Rose Excellence in Research Award for the paper entitled, "Effectiveness of Manual Physical Therapy and Exercise in Osteoarthritis of the Knee: A Randomized, Controlled Trial" published in the *Annals of Internal Medicine* 2000;132(3):173-181. The coauthors for this article are Nancy Henderson, Robert Matekel, Michael Ryder, Matthew Garber, and Stephen Allison. Colonel Deyle is currently the Chief of Physical Therapy at the Brooke Army Medical Center in San Antonio, Texas. He received his Master of Physical Therapy degree from Baylor University and is near completion of the Doctor of Physical Therapy degree at Creighton University. He has completed the Kaiser Hayward Orthopaedic Residency Program and is an Orthopaedic Certified Specialist. He has shown leadership in the development of the clinical residency by founding the US Army Orthopaedic Clinical Residency Program, which is accredited by both the APTA and the AAOMPT. He has most recently served the Orthopaedic Section on the Task Force for a Model Curriculum for Residency Training. He also serves as adjunct faculty for Rocky Mountain University of Physical Therapy and Creighton University. The paper for which this award is given is an excellent model for clinical research, and we extend warm congratulations to Gail and his colleagues on this outstanding work.

Occupational Health Physical Therapists Special Interest Group

Orthopaedic Section, APTA, Inc.

Spring 2001 Volume 13, Number 1

OSHA's Ergonomics Program Standard: What is the Role of the Health Care Professional?

John R. Stevenson, PhD, PT, CEA
Research Committee Chair, OHSIG

In November 2000, the Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor released the regulatory text of the final Ergonomics Program Standard. Although the final document is over 600 pages in length, the ergonomics standard regulatory text (OSHA Standard 1910.900) is described in detail in the final 20 pages, accompanied by the relevant appendices. The remaining pages, considered to be a 'preamble,' serve as the research and evidenced-based background concerning the need and support for the standard. The official version of the regulatory text can be found in the ***Federal Register***[1] or can be accessed through OSHA's website, www.osha.gov/.

HISTORY

The history of development of the standard has its roots in the early years of the Clinton administration and the standard began to take shape in 1994 with the work of Drs. Barbara and Michael Silverstein. During 1995, the preliminary draft was circulated for review and comment. Shortly thereafter the U.S. Congress affected the process by attaching riders that were later lifted in 1997. Final preparation of the proposed standard proceeded with revision and input from various public hearings scheduled across the country where over 700 experts, professional groups, and citizens offered testimony regarding the proposed standard. The standard went into effect on January 16, 2001, with a compliance date of October 15, 2001.

PURPOSES

Since one of the purposes of the Occupational Safety and Health Act of 1970 is "...to assure...every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources..." OSHA was given authority, and empowered, to promulgate standards, as well as oversight responsibilities concerning compliance and citations. The OSH Act contains the General Duty Clause that states that each employer shall furnish employment free from recognized hazards. From its inception, OSHA has tracked the scientific knowledge concerning work-related musculoskeletal disorders (MSDs), especially from the areas of biomechanics, physiology, pathophysiology, and epidemiology. Also, the National Institute for Occupational Safety and Health

(Continued next page)

Attention Clinical Sites Potential Research Collaboration

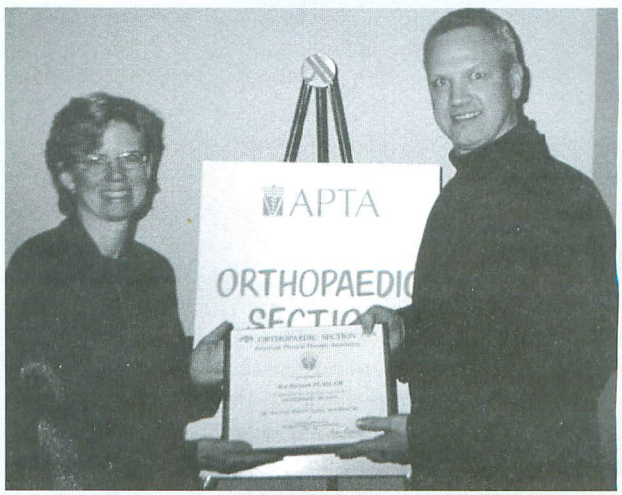
As you may be aware, major efforts are being made to develop *Clinical Research Networks*. The development of such networks will require clinical sites that can contribute to successful collaboration of researchers and clinicians.

To be prepared for the development of proposals, the Occupational Health Physical Therapy SIG is collecting the names of clinical sites that may be interested in such collaboration. This list will be supplied to research groups that may submit proposals for the development of a *Clinical Research Network*.

Please contact Scott D. Minor, PT, PhD, at minors@msnotes.wustl.edu if you are interested in having your clinical site listed. Please include your name, credentials, title, clinic name, street address, telephone number, and e-mail address (if available) when you contact Dr. Minor. Dr. Minor will be happy to answer any questions you have before you submit your clinic name for listing.

Ken Harwood Recognized for his Contribution to the OHSIG

On Friday, February 16, 2001 the Occupational Health Special Interest Group held its annual Business Meeting at CSM in San Antonio, TX. Kenneth J. Harwood, PT, PhD, CIE of Columbia University was recognized by the SIG's President, Deborah E. Lechner, PT, MS for his grateful participation as the Nominating Committee Chairman. A new task for Ken is to begin the practice analysis for definition of occupational health physical therapy. If there is a Section member interested in joining Ken's committee, they can contact Dr. Harwood at 212/305-3781.



Ken is receiving a plaque for his services from OHSIG President, Deb Lechner.

(Continued from page 27)

(NIOSH), OSHA's counterpart in the Centers for Disease Control (CDC), has provided evidence regarding incidence, severity, and mechanisms of work-related MSDs. A NIOSH review has found evidence for causal exposures for MSDs for work involving repetition, force (with "strong evidence" for lifting), and posture (with "strong evidence" for neck/shoulders). "Strong evidence" was also found for both segmental and whole body vibration and for combinations of exposures such as force and repetition or force and vibration. In addition, the research literature in ergonomics, human factors, occupational health, and occupational biomechanics has provided numerous high-quality studies or reviews that provide evidence for the work-relatedness of MSDs for the upper extremity and back, as well as for general considerations and psychosocial stressors.

So why did OSHA propose and develop the current ergonomics standard? The answer lies in the growing body of research evidence concerning the etiology of, and risk factors for, work-related MSDs, the injury evidence provided by the Bureau of Labor Statistics (BLS), OSHA's experience with the good outcomes and experiences of employers' programs designed to reduce the incidence and severity of occupational injuries and illnesses, and as a proactive method to address the growing number of citations under the general duty clause of the OSH Act.

The purpose of the ergonomics program standard is to reduce the number and severity of MSDs caused by exposure to ergonomic risk factors in the workplace. According to data from the Bureau of Labor Statistics, 1 of every 3 injuries is a MSD. Also, carpal tunnel syndrome (CTS) results in an average of 25 lost workdays, more than any other injury. In addition, $1 of every $3 in worker's compensation is for an MSD, with the average cost about $27,000. The ergonomics standard's scope and coverage applies to employers in general industry only; the railroads, construction, maritime, and agriculture industries are not included since they are covered under different rules. Employers who already have a written, active ergonomics program in place can be 'grandfathered' in under compliance if the written program was implemented before 11/14/2000 and contains: (1) management leadership/employee participation, (2) job hazard analysis, (3) training, (4) program evaluation before 1/16/2001, (5) has MSD management in place by 1/16/2002, and 6) does not discourage reporting or participation. For employers in general industry who do not meet the 'grandfather' criteria, the initial action required is to provide or make available to employees by October 15, 2001: (1) basic information about MSDs signs/symptoms, reporting, early reporting, and jobs and risk factors associated with MSDs; and (2) summary of the requirements of the standard. In short, the standard says employers must develop and implement an ergonomics plan designed to evaluate the risks of MSDs and establish a process for employees to report and be treated for any job-related MSDs that occur.

THE PROCESS

It is an employer's obligation to report any work-related MSD incident if it meets any of the following criteria: (1) it requires medical treatment beyond first aid, (2) it results in restricted work, (3) it requires days away from work, or (4) symptoms last 7 or more days after reported. Once an injury has been determined to be a work-related MSD incident, the employer must determine whether the job meets the standard's Action Trigger. The Action Trigger is met if: (a) an MSD incident has occurred in that job, and (b) the job routinely involves, on one or more days a week, exposure to one or more risk factors in Table W-1, the Basic Screening Tool.

The Basic Screening Tool lists 12 activities that are covered by the standard. The activities are further defined by the part of the body that was injured. For example, if the hand or wrist were injured one activity that might apply would be "using an input device such as a keyboard and/or mouse, in a steady manner for more than 4 hours total in a workday." If the employee reported a back MSD then that activity would not apply. If the employee reporting the MSD incident did not use a computer or did not work on data entry for 4 hours, then that activity would not apply. If the employer cannot find an activity on the basic screening tool that applies to the employee, then the job is not covered by the standard, regardless of the fact that an MSD incident had occurred.

If any job meets the Action Trigger, then the two options available are to provide a Quick Fix or develop and implement an ergonomics program designed to address the problems of the job. The Ergonomics Program Standard specifies that an ergonomics program must contain the elements of: management leadership, employee participation, MSD management, job hazard analysis, hazard reduction and control, training, and evaluation. *Management leadership* includes responsibilities for setting up and managing the ergonomics program, providing the resources necessary to meet the responsibilities, and to ensure that policies and procedures encourage participation in the program and do not discourage such participation. *Employee participation* includes having ways of reporting MSDs, responding promptly if MSDs occur, and being involved in the development, implementation, and evaluation of the ergonomics program.

Determination if a job poses an MSD hazard involves conducting a job hazard analysis or relying on a previous analysis where appropriate. Such determination needs to include employees in the same job at the greatest risk and can include talking to the employees, observation of the job, and determining if the hazard is limited to the individual. To determine if a job poses an MSD hazard, employers can use: one or more of the hazard identification tools in Appendix D-1, the occupation-specific tool of Appendix D-2, a job hazard analysis conducted by a trained professional, or other reasonable methods appropriate and relevant to the risk factors. According to the standard, if there is an MSD hazard it is classified as a "problem job" and needs to be addressed in the ergonomics

program through controls such as engineering, work practice, administrative, or a combination thereof. The obligation to reduce MSD hazards in a problem job can be satisfied by controlling the MSD hazards, reducing the hazards below levels in Appendix D (ie, below the Action Trigger), or reducing the hazards to the extent feasible, which requires the added steps of assessing every 3 years and implementing controls as they become available.

The Quick Fix process involves employee input in identifying the risk factors, recommending measures to reduce exposure to the MSD hazards identified, implementing controls to reduce the hazards to levels below those in the hazard identification tools (Appendix D), and training the employees in the use of these controls. It is available only if no more than one MSD occurs on that job, or no more than two MSD incidents occur in the establishment in the last 18 months. Following employee input for recommendations to reduce job hazards, the employer must implement controls below the Action Trigger within 90 days, evaluate within 30 days after implementation of controls, and keep a record of that job. If controls reduce job hazards below the Action Trigger, then maintenance of the controls is sufficient. If not below the Action Trigger, then the employer must implement a full ergonomics program as outlined above.

For MSD management, employers must provide the employee at no cost: (1) prompt and effective MSD management including access to a Health Care Professional (HCP); (2) any necessary work restrictions, including time off work to recover; (3) work restriction protection for medical work restrictions; and (4) evaluation and follow-up of the MSD incident. In terms of training, the employer must provide training to employees in jobs that meet the Action Trigger, their supervisors or team leaders and other employees involved in setting up and managing the ergonomics program. Finally, program evaluation requires the employer to evaluate the program to make sure it is effective by consulting employees, reviewing program elements for effectiveness, determine if MSD hazards are being identified and addressed, determine if the program is achieving positive results, and correct deficiencies.

ROLE OF THE HEALTH CARE PROFESSIONAL

The standard defines health care professionals as physicians or other licensed health care professionals whose legally permitted scope of practice (eg, license, registration, or certification) allows them to provide independent practice or to be delegated the responsibility to carry out some or all of the MSD management requirements of the standard. According to Gary Orr, PE, CPE, formerly of OSHA who contributed to the development of the standard, this definition was specifically broadened to be inclusive of qualified health care professionals rather than

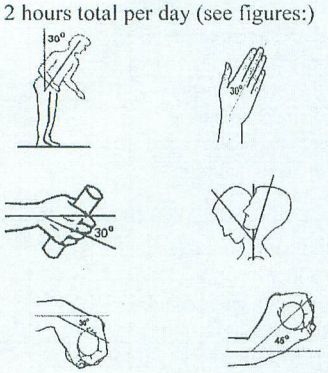
Table W-1. Basic screening tool. You need only review risk factors for those areas of the body affected by the MSD incident.

		Body Part Associated With MSD Incident			
Risk Factors This Standard Covers	**Performing job or tasks that involve:**	**Neck/ Shoulder**	**Hand/ Wrist/ Arm**	**Back/ Trunk/ Hip**	**Leg/ Knee/ Ankle**
Repetition	(1) Repeating the same motions every few seconds or repeating a cycle of motions involving the affected body part more than twice per minute for more than 2 consecutive hours in a workday.				
	(2) Using an input device, such as a keyboard and/or mouse, in a steady manner for more than 4 hours total in a workday.				
Force	(3) Lifting more than 75 pounds at any one time; more than 55 pounds more than 10 times per day; or more than 25 pounds below the knees, above the shoulders, or at arms' length more than 25 times per day;				
	(4) Pushing/pulling with more than 20 pounds of initial force (e.g., equivalent to pushing a 65 pound box across a tile floor or pushing a shopping cart with five 40 pound bags of dog food) for more than 2 hours total per day;				
	(5) Pinching an unsupported object weighing 2 or more pounds per hand, or use of an equivalent pinching force (e.g., holding a small binder clip open) for more than 2 hours total per day;				
	(6) Gripping an unsupported object weighing 10 pounds or more per hand, or use of an equivalent gripping force (e.g., crushing the sides of an aluminum soda can with one hand), for more than 2 hours total per day.				

exclusive to physicians, specifically occupational health physicians, due to their relative low numbers as compared to the millions of employees and thousands of companies covered by the standard. Whenever an employee consults an HCP for MSD management, the employer must provide the HCP with: (1) a description of the employee's job and information about the physical work activities, risk factors, and MSD hazards in the job; (2) a copy of the Ergonomics Program Standard; and (3) a list of information that the HCP's opinion must contain.

The HCP's opinion must contain assessment of the employee's medical condition as related to the physical work activities, risk factors, and MSD hazards in the employee's job, any recommended work restrictions, including, if necessary, time off work to recover, and any follow-up needed. Also, the HCP must provide a statement that the employee has been informed of the results of the evaluation, the process to follow to affect recovery, any medical conditions associated with exposure to physical work activities (eg, diabetes, obesity, CAD), risk factors and MSD hazards in the employee's job (eg, repetitive lifting, static postures, forceful grasps), and the HCP must provide a statement that the employee also has been informed about work-related or other activities that could impede recovery from the injury. If the employer selects an HCP to make a determination about temporary work restrictions or work removal, the employee may select a second HCP on his or her own (at their expense). In the event of different findings and/or recommendations, a third HCP will be designated to review the determinations.

Table W-1. Continued

		Body Part Associated With MSD Incident			
Risk Factors This Standard Covers	**Performing job or tasks that involve:**	**Neck/ Shoulder**	**Hand/ Wrist/ Arm**	**Back/ Trunk/ Hip**	**Leg/ knee/ Ankle**
Awkward Postures	(7) Repeatedly raising or working with the hand(s) above the head or the elbow(s) above the shoulder(s) for more than 2 hours total per day;				■
	(8) Kneeling or squatting for more than 2 hours total per day;	■	■		
	(9) Working with the back, neck or wrists bent or twisted for more than 2 hours total per day (see figures:) 				■
Contact Stress	(10) Using the hand or knee as a hammer more than 10 times per hour for more than 2 hours total per day;	■		■	
Vibration	(11) Using vibrating tools or equipment that typically have high vibration levels (such as chainsaws, jack hammers, percussive tools, riveting or chipping hammers) for more than 30 minutes total per day;				■
	(12) Using tools or equipment that typically have moderate vibration levels (such as jig saws, grinders, or sanders) for more than 2 hours total per day.			■	■

CONCLUSION

In summary, the benefits of the standard may be realized in cost savings, eg, the cost to control an MSD is about 5% of the cost to treat an MSD, as well as improving treatment since MSDs that are reported early are easier to treat. Jobs with MSDs result in turnover, absenteeism, errors, and poor performance, so employers should see immediate benefits not only in terms of economics but also in improvements in employee morale and quality of life, both at work and off work. As occupational health care professionals, physical therapists can play major roles in implementation and compliance with the Ergonomics Program Standard, thereby ensuring improved quality of life through reduction of MSDs and improvement of function in occupational settings. When considered at the level of specialized practice for evaluation and examination, intervention, prevention, and patient education, we can have a significant effect on the impact of the standard and the employees it covers. If just considered at a basic level, it's the right thing to do.

FOOT & ANKLE

SPECIAL INTEREST GROUP
ORTHOPAEDIC SECTION, APTA, INC.

Greetings Everyone!

It seems as though the FASIG board members spend all year getting prepared for the CSM FASIG activities and before you know it, the meeting comes and passes so quickly. Again this year, as in years past, both the FASIG educational program as well as the business meeting was extremely successful and productive.

As usual, Mark Cornwall, Vice-President, did an exceptional job in organizing the FASIG educational programming session on the topic of "Management of Lower Extremity Injuries in Runners." A special thanks to all of the presenters including: Blaise Williams, Melissa Hatley, and Irene McClay. The educational session was extremely well received with over 300 attendees throughout the entire session.

As I previously noted, the FASIG Business Meeting was also quite productive with over 20 members attending at the conclusion of the Friday evening programming. While the official minutes of the meeting are attached to my report, I did want to give you a few of the highlights of the Business Meeting.

In my President's Report, I noted that the FASIG was very successful in meeting the goals it had established for the past year. These goals included:

- *Establish liaisons in each state to monitor practice issues and report back to the FASIG on an annual basis:*
  - I reported that the FASIG Executive Board has worked very hard to promote physical therapy orthopaedic foot and ankle practice amongst various national foot and ankle organizations including the Pedorthic Footwear Association, the American Podiatric Medical Association, and the American Academy of Orthotics and Prosthetics.
  - Steve Reischl has served as the official FASIG liaison to the American Orthopaedic Foot & Ankle Society and provided a report on those activities to the membership at CSM.
  - That one of the purposes for conducting a survey of the FASIG membership was to determine the distribution of FASIG members in each state so that liaisons to monitor practice issues can be identified.
  - To sponsor a research retreat entitled "Static and Dynamic Classification of the Foot."
  - The research retreat was held in Annapolis, MD in May 2000, with 30 participants that included registrants from both Canada and Australia attended the meeting. The group was made up of podiatrists, physical therapists, biomechanists, and footwear specialists, all with an interest in foot and ankle research. The objective of the retreat was to examine the area of static and dynamic classification of the foot through the presentation of research findings with the mission of developing a consensus regarding future research directions. ***Based on participant evaluations, the meeting was a great success.*** It is hoped that the FASIG can sponsor another retreat in two years.
- *A FASIG survey of the membership.*
  - Steve Reischl, chair of the FASIG Survey Subcommittee, presented preliminary results of the survey to the membership at the business meeting. The purpose of the survey was to establish a database of those physical therapists currently providing various levels of foot and ankle care as well as to gain insight into the number of FASIG members actively involved in providing foot and ankle services. Steve will be publishing a report on the results of the survey in the next issue of *Orthopaedic Practice*.
- *To continue to serve as a clearinghouse for inquires from physical therapists and nontherapists via email or telephone regarding the management of various foot and ankle disorders.*
  - Approximately 100 inquiries were made to the FASIG over the past year.
  - Many of the referrals to the FASIG were directly from the Orthopaedic Section office or APTA.

Based on election results, I want to congratulate Steve Reischl, President; Steve Paulseth, Secretary-Treasurer; and Steve Baitch; Nominating Committee. I know that all 3 of these exceptional clinicians will provide an outstanding level of leadership for the FASIG over the next 2 years.

Vice-President Mark Cornwall has requested that ideas for upcoming CSM programming be sent to him via email (Mark.Cornwall@nau.edu) or fax (520.523.9289). Mark also reported that the FASIG home page continues to be an active site. The web page provides excellent exposure to both the FASIG as well as the Orthopaedic Section.

In closing, I want to thank my fellow Executive Board members as well as all the FASIG membership for making my term as President over the past 2 years so enjoyable. It has been great to watch the FASIG continue to develop as well as serve an important function for the Orthopaedic Section. I also want to thank the Orthopaedic Section Board of Directors and the Section office staff for all their support for FASIG activities over the past two years. I encourage all of you with an interest in the Foot & Ankle to become actively involved with the FASIG and support our new President, Steve Reischl. The success of the FASIG is directly related to the involvement of the Orthopaedic Section members such as you! I look forward to seeing each of you at 2002 CSM in Boston.

Best Regards as Always,
Tom McPoil

Minutes of the Foot and Ankle Special Interest Group (FASIG) Meeting
February 16, 2001
Combined Sections Meeting of the APTA,
San Antonio, TX

Tom McPoil called the meeting to order at 4:36pm. There were 17 individuals in attendance.

Motion: It was moved by Susan Appling and seconded by Steve Baitch to approve the minutes of the February 4, 2000 meeting of the FASIG in New Orleans, LA.
Passed by unanimous vote.

Officer/Committee Reports:

- Chair: Tom McPoil reported on a request from the Orthopaedic Section Board to revise our bylaws so that they are consistent across all SIGs. This request would involve the separation of the Secretary/Treasurer position into 2 positions. It was the unanimous opinion of those present that the Secretary and Treasurer position not be separated.
- Vice-Chair: Mark Cornwall reported on the success of this year's programming, which involved evaluation and management of the injured runner. Over 350 individuals attended the programming. He reported that plans were currently underway for next year's programming that will take place in Boston, MA. Suggestions, comments, and ideas are always welcome.
- Secretary/Treasurer: Dave Sims's was not present and Tom McPoil gave his report. The SIG continues to have sufficient funds for its regular operations, but the amount in reserve for extra programs and activities is significantly lower as a result of the recent Research Retreat. Ideas and plans concerning ways to increase the reserve were discussed.
- Research Committee: Irene McClay reported on the Research Retreat that was held May 19-20, 2000 in Annapolis, MD. The topic of the retreat was "Classification of the Foot." There were 30 participants with 14 presentations and 4 keynote addresses. Participants were from the US, Canada, and Australia and represented several different professions (PT, DPM, and Biomechanists). Because of the overwhelming opinion by those who attended regarding its benefit, another retreat is anticipated for 2002 or 2003. The topic for that retreat is yet to be determined.

Old Business:

- Steve Reischl presented preliminary results on the recent survey of Orthopaedic Section members concerning interest and scope of practice in the foot and ankle. The survey was printed in *Orthopaedic Physical Therapy Practice* and 122 individuals returned the survey. The results indicated that:
  - A majority of respondents were in outpatient settings
  - Either sports medicine or geriatrics was the most common type of patient
  - Common diagnoses seen included achilles tendonitis, posterior tibialis tendonitis, sprains, and heel pain
  - A wide range of different types of foot orthoses were reported being used by the respondents

  A complete summary of the survey's results will appear in a future issue of *Orthopaedic Physical Therapy Practice*. Discussion from the floor included making the survey more widely available via the SIG web site.

FOOT & ANKLE OFFICER LISTING

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New Business:

- It was requested that the SIG explore ways to be more involved in public relations activities.
- Steve Paulseth asked that the current SIG web site be updated and expanded to help meet the needs of the membership. Mark Cornwall will explore options available through the Orthopaedic Section office.

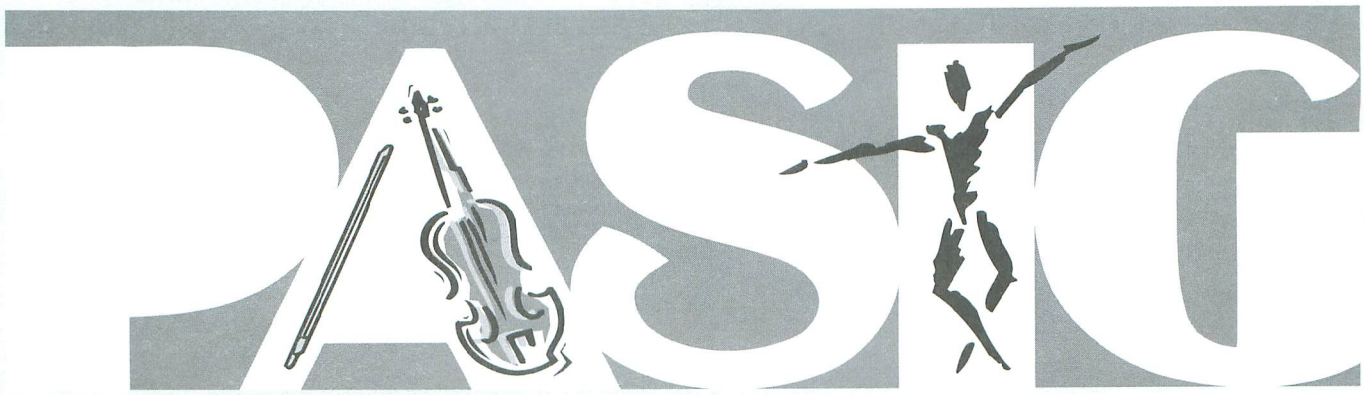
Elections:

- The following individuals were elected to positions within the FASIG.
  - Steve Reischl — Chair (2001-2003)
  - Steve Paulseth — Secretary/Treasurer (2001-2003)
  - Tom McPoil — Nominating Committee (2001-2003)
  - Steve Baitch — Nominating Committee (2001-2003)

As a matter of information, Byron Russell will serve as the Chair of the Nominating Committee for this next year.

With no further business, old or new, the meeting was adjourned at 5:45pm.

Respectfully submitted,
Mark Cornwall
Vice Chair, FASIG



Performing Arts Special Interest Group • Orthopaedic Section, APTA

MESSAGE FROM THE PRESIDENT

Welcome back from San Antonio. It was great to see so many faces at our programming. We got great feedback for all of our presentations. Many thanks to our presenters Peter Edgelow, Barrett Dorko, Tara Jo Manal, Mark Erickson, and Susan Stralka, as well as our research panel, Kathryn Roach, Linda Van Dillen, and Nancy Byl.

This is a big year for the PASIG. We are undertaking some big organizational changes, primarily with the addition of Regional Directors who will report to Jeff Stenback. We have identified 6 regions and have already appointed directors to 4 of those regions. Welcome to Marshall Hagins, Marijeanne Liederbach, Tara Jo Manal, Edie Shinde, Mark Erickson, and Julie O'Connell. We look forward to hearing more news from the local level, and being more efficient at transmitting news back to the membership. We are looking for 5 additional regional directors, so if you are interested in participating, please contact Jeff Stenback.

The PASIG is about to kick off our practice analysis – a project that the Orthopaedic Section is funding for 2001-2002. The first meeting of our National Advisory Group will be held in March in Arlington, VA. Anyone who is interested in hearing more about the process, please drop me an e-mail note.

As we are embarking on an exciting new year, we must also say goodbye to 2 of our Executive Board members. Nick Quarrier, outgoing Vice-President and Education Committee Chair has done a fabulous job designing and coordinating our educational programming for the past 3 years. He has also contributed in countless other ways to the growth and development of the SIG. We will miss him on the Board, but look forward to his continued involvement with the PASIG. Donna Ritter has also completed her term as Secretary. We appreciate her stepping into Shaw Bronner's place, immediately rolling up her sleeves, and helping the Executive Board continue to function. We also look forward to Donna's continued involvement in the SIG.

Amy Wightman, Chair of the Nominating Committee and her fellow committee member, Lynn Medoff, did a great job recruiting candidates on a very tight timeline, so we also welcome new members to the Executive Board and to the Nominating Committee. Congratulations to Lynn Medoff, our new Vice President, Susan C. Guynes, our new Secretary, and Terry Sneed and Monica Merry, our new Nominating Committee members. Just a quick note about next year's elections – we will be electing a new President, a new Treasurer, and a new Nominating Committee member, so if you are interested, let Amy know.

That's it for now. As always, we encourage you to get involved.

Jennifer M. Gamboa, MPT
President

2001 PASIG Business Meeting Minutes
Combined Sections Meeting
San Antonio, Texas
February 16, 2001

CALL TO ORDER and WELCOME – 4:30 PM –
Jennifer Gamboa, President

MOTION: To approve the minutes from the Business Meeting at CSM in New Orleans, Louisiana, on February 4, 2000, as printed in the Spring 2000 issue of *Orthopaedic Physical Therapy Practice*. **PASSED.**

EXECUTIVE COMMITTEE REPORT:
A. Jennifer Gamboa, President:

The Regional Director position has been developed under the PR/Media Relations Committee to meet the PASIG objective of maintaining closer communication with PASIG members.

MOTIONS: Action has been taken regarding 2 motions passed at the 2000 PASIG Business Meeting.

MOTION 1: To conduct a formal practice analysis and to have the Executive Committee comprise a task force that would identify content experts for such an analysis.

Result: PASIG has received funding from the Orthopaedic Section to conduct such practice analysis in 2001-2002, and preparations are underway as of this date.

MOTION 2: To investigate national interstate licensing.

Result: The motion was brought by the PASIG to the Orthopaedic Section Practice Committee at the 2000 CSM Orthopaedic Section Business Meeting. That committee is currently investigating this issue.

B. Jeff Stenback, Treasuer:

Presented 2001 PASIG Budget. PASIG receives $5,000 from the Orthopaedic Section.

NOMINATING COMMITTEE: Elections for Vice-President, Secretary, and 2 Nominating Committee members were held by the Executive Committee in the absence of nominating committee members. Terms are 3 years.

Election Results: 19 ballots returned with unanimous vote.

Vice-President: Lynn Medoff, MPT, MA
Secretary: Susan C. Guynes, PT, MHS
Nominating Committee members: Terry Sneed, PT, ATC and Monica Michalski Merry, MPT, OCS, Cert. MDT

NEW BUSINESS:

The Orthopaedic Section has revised all SIG Bylaws to make them consistent with both Orthopaedic Section and APTA Bylaws. The language and content of the Bylaws has not been substantively changed.

OPEN FORUM / DISCUSSION:

CSM Programming: PASIG members suggested revisiting combining CSM educational programming with other SIGs or Sections in order to expand our programming hours, as this has been successful in the past. Suggestion was made to offer programming that addresses interests of both practitioners with a high level of skill and those with a need for basic topics in physical therapy approach to performing artists, with the goal of nurturing new members as well as challenging more experienced members.

MOTION: To review the *Guide to Physical Therapist Practice, 2nd Edition* to generate ideas and a framework for PASIG educational programming. **PASSED.**

MEETING ADJOURNED: 5:30 PM

Donna Ritter, PT
Outgoing Secretary

CSM 2001 PASIG PROGRAMMING

The PASIG educational program at CSM was a big success! Peter Edgelow presented a fascinating talk on evaluating and treating upper extremities with positive upper limb tension tests. His protocol sounds very exciting and seems to produce excellent results. Barrett Dorko followed with a second fascinating discussion about the performer's inherent ideomotor movement and the need to elicit this to help reduce and manage chronic pain. Tara Jo Manal discussed the positive effects of high intensity noxious electrical stimulation for pain control. Mark Erickson presented a screening tool for dance injuries. The program ended with 2 presentations which were enthusiastically reviewed by our research panelists, Linda Van Dillen, and Kathy Roach. Susan Stralka discussed a project that examined the effects of thoracic mobilization on the autonomic nervous system, and Jennifer Gamboa presented a number of case reports examining the use of diagnostic dynamic ultrasound in dancer's ankle dysfunctions.

Nick Quarrier, PT, MHS, OCS
Outgoing V.P.—Education Committee Chair

PASIG BUDGET 2001

Activities	Expense	Budget
A. General Expenses		1000
Stationery/Supplies	100	
Telephone/Fax	750	
Postage/Shipping	75	
Miscellaneous	75	
B. Travel Assistance for Executive Board to attend CSM ($650/person X 4)		2600
C. Reception at CSM 2001		0
Meeting Services	0	
D. Programming for CSM		250
Travel – CSM	0	
Lodging/Meals – CSM	0	
Speaker Honorarium – CSM (2 speakers)		250
E. Mailings to PASIG Membership		295
Postage/Shipping	210	
Printing	85	
F. Membership Directory		210
Postage/Shipping	90	
Printing	120	
G. Development/Maintenance Web Page		120
Professional Fees	120	
H. Brochure/Press Kit Development		375
Printing	375	
I. Membership Pins (Currently in stock)		0
J. Nominations		150
Postage/Shipping	150	
TOTAL		$5000

Jeff Stenback, PT, OCS
Treasurer

GET INVOLVED IN THE PASIG AND THE FUTURE IS YOURS!

Join your fellow PASIG members in becoming an ambassador for the Performing Arts! The PASIG wants to encourage all our members to become actively involved by serving as committee members, regional directors, officers, and by offering your input at business meetings and through communication with other PASIG members. Remember, when you give of your time and energy to the PASIG, it's like giving a gift to yourself! The PASIG is only as strong as its members.

COMMITTEE UPDATES

Committee objectives are formally outlined and described below. The committees are responsible for fulfilling and carrying out the PASIG's purpose and objectives. All committees will meet with the president in March to develop strategic plans for the year. Committee membership involves a 3-year commitment. Some committees still need members. If you have an interest in committee involvement, please contact the Committee Chairperson. They are listed in the Directory on the last page of this newsletter.

PRACTICE COMMITTEE

PURPOSE: To develop, in coordination with the membership, practice guidelines and standards for performing arts physical therapy; to assist in development and implementation of student affiliations as well as advanced clinical training; to serve as an advocate for performing arts physical therapy practice issues; to facilitate communication among members regarding practice patterns and exchange of clinical information.

OBJECTIVES: (1) Assist the practice analysis steering committee in the development of a Description of Advanced Clinical Practice for Performing Arts Physical Therapy; (2) Develop, maintain, and disseminate a list of active student affiliation and mentorship sites; (3) Act as a liaison between the PASIG and appropriate governing authorities regarding interstate practice licensing issues; (4) Develop a compendium of current information regarding interstate licensing issues; (5) Develop a universal screening tool(s) for use with the performing arts community; (6) Act as a clearing house for exchange of clinical information among clinicians.

ROLES: 4 members; Estimated time commitment of 8 hrs/quarter. NEEDS: 2 members

2000-2001 Activities: Getting the Practice Analysis of performing arts physical therapy underway, including gaining funding, scheduling and arranging meetings, recruiting content experts to compose the National Advisory Group, and initiating the relevant literature review.

EDUCATION COMMITTEE

PURPOSE: To develop and coordinate 3 hours of annual Combined Sections Meeting programming for PASIG membership; to coordinate with Research Committee for 1 hour of annual "Dialogues in Performing Arts Research" programming.

OBJECTIVES: (1) Develop annual programming concepts; (2) Identify, solicit, and obtain commitments from potential speakers; (3) Coordinate program planning and speaker responsibilities; (4) Implement programming at CSM.

ROLES: 2 members; Estimated time commitment of 10 hrs. in the 1st and 2nd quarters; 3 hrs. in the 3rd & 4th quarters. NEEDS: 2 members

2000-2001 activities: Arranged educational programming for CSM 2001.

RESEARCH COMMITTEE

PURPOSE: To facilitate research in physical therapy for the performing arts; to facilitate dissemination of research relevant to performing arts physical therapy.

OBJECTIVES: (1) Develop annually 1 hour of "Dialogues in Performing Arts Research" programming; (2) Coordinate "Dialogues" programming with education committee; (3) Develop specific mechanisms for promoting and facilitating performing arts physical therapy research.

ROLES: 2 members; Estimated time commitment of 2 hrs. in the 1st and 2nd quarters; 3 hrs. in the 3rd and 4th quarters. NEEDS: 1 member

PUBLIC/MEDIA RELATIONS COMMITTEE

PURPOSE: To raise awareness of Performing Arts physical therapy within the physical therapy profession, the performing arts community, and the public at large; to assist members in marketing their services to the performing arts community; to act as a clearing house for clinical pearls, regional news, and specific membership achievements; to act as an ambassador for performing arts clinicians.

OBJECTIVES: (1) Develop the quarterly regional news column (published in *OPTP*); (2) Develop a network of regional directors; (3) Collect a compendium of performing arts physical therapy articles suitable for publication/media release; (4) Facilitate development of PASIG special topic advisories; (5) Develop a media plan for disseminating press releases, special topic advisories, and specific articles regarding performing arts physical therapy, to our target markets.

ROLES: 4 members, 12 regional directors; Estimated time commitment of 3 hrs/quarter. NEEDS: 1 member

2000-2001 Activities: Began development of a compendium of performing arts physical therapy articles and helped get articles published in regional publications; developed the plan for Regional Directors.

Regional Directors: Subcommittee of the Public/Media Relations Committee

PURPOSE: To highlight regional activities of the performing arts physical therapy community, and PASIG members in particular; to foster communication and interaction among PASIG members; to act as an ambassador for the PASIG Executive Board to the regional members.

RESPONSIBILITIES: (1) Directly contact regional PASIG members on a quarterly basis to obtain and exchange PASIG information and news; (2) Report back to the Public/Media Relations Chair; (3) Maintain accurate contact information on regional members and coordinate that information with the membership committee.

ROLES: 12 directors (2 per region); Estimated time commitment of 3 hrs/quarter. NEEDS: 1 director for Mid-Atlantic region, 2 directors for Northwest region, 2 directors for Western region

The country has been divided into 6 regions as follows:
Northeast (Connecticut, Maine, Massachusetts, New Hampshire, New York, Vermont)
Mid-Atlantic (Delaware, Maryland, New Jersey, North Carolina, Pennsylvania, Virginia, Washington DC, West Virginia)
South (Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, South Carolina, Tennessee)
Central (Arkansas, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Ohio, Oklahoma, Wisconsin)
Northwest (Idaho, Montana, Nebraska, North Dakota, Oregon, South Dakota, Washington, Wyoming)
West (Alaska, Arizona, California, Colorado, Hawaii, Nevada, New Mexico, Utah, Texas)

MEMBERSHIP COMMITTEE

PURPOSE: To develop outreach mechanisms to increase retention of current members and recruitment of new members.

OBJECTIVES: (1) Update membership directory every 2 years in coordination with Orthopaedic Section office, and the PASIG Education Committee; (2) Develop welcome package for new/returning PASIG members, and implement a mechanism for timely dissemination; (3) Regularly update PASIG Web Page (www.orthopt.org/painde.html) in coordination with Orthopaedic Section office; (4) Coordinate annual PASIG Social Event at CSM.

ROLES: 2 members; Estimated time commitment of 6 hrs/quarter

NEEDS: 2 members

Activities: Newly formed in 2001. Has begun development of a membership welcome packet.

NOMINATING COMMITTEE

PURPOSE: To support the growth and development of the PASIG by recruiting candidates with a variety of performing arts experiences. Such diversity may be reflected with respect to practice setting, geographical region, and skill level of patient population; to act as ambassador of the Performing Arts SIG to the physical therapy community at large.

OBJECTIVES: (1) Develop and publish a slate of candidates for relevant positions on annual basis; (2) Conduct elections in accordance with PASIG Bylaws; (3) Chairperson to serve as liaison to Executive Board.

ROLES: Elected position for 3-year term; Senior member serves as Chairperson; Estimated time commitment of 4 hrs/quarter.

NEEDS: Candidates needed on annual basis, as a new member is elected annually.

PASIG EXECUTIVE COMMITTEE

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(contact info above)

Practice Committee Chair:
Jennifer M. Gamboa, MPT
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Members: Mark Erickson, Marshall, Hagins, Nick Quarier, Donna Ritter, Jeff Stenback

Nominating Committee Chair:
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Members: Monica Michalski Merry, Terry A. Sneed

Public/Media Relations Committee Chair:
Jeff Stenback, PT, OCS
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Members: Joe Berman, Susan Guynes, Jill Olsen

Regional Directors (Subcommittee of Public Media Relations Committee)

- Northeast (CT, MA, ME, NH, NY, RI, VT)
  Marshall Hagins, Marijeanne Liderback
- Mid-Atlantic (DE, DC, MD, NC, NJ, PA, VA, WV)
  Tara Jo Manal
- South (AL, FL, GA, KY, LA, MS, SC, TN)
  Edie Shinde, Jeff Stenback
- Central (AR, IL, IN, IA, KS, MI, MN, MO, OH, OK, WI)
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Jennifer M. Gamboa, MPT
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Members: Scott Stackhouse

Pain MANAGEMENT

SPECIAL INTEREST GROUP • ORTHOPAEDIC SECTION, APTA, INC.

President's Message

This is my last letter to you as President of the Pain Management Special Interest Group of the Orthopaedic Section of the American Physical Therapy Association. Seven years ago at an American Academy of Pain Management Meeting in Vancouver, Canada, Gaetano (Gerry) Scotese, PT, John Garzione, PT, and I sat down with several other physical therapists and discussed the formation of a special interest group on pain management. We approached the Orthopaedic Section of the APTA and received approval to form a SIG. Gerry Scotese and I sat down and wrote the bylaws for the Pain Management Special Interest Group. Gerry became the first President, I was the Vice President, and John Garzione has served as the Secretary for the past 6 years. I assumed the presidency in 1996 following the untimely passing of Gerry.

The Pain SIG has provided programming to the Orthopaedic Section at CSM over the past many years including: Cold Laser Therapy, Chronic Pain and Exercise, Psychological Aspects of Pain, Industrial Rehab and Anatomy of Pain, and the preconference course of the 2001 CSM—The Paradigm of Physical Therapy and Pain in the 21st Century.

A new slate of officers has been nominated. They come highly recommended and include Joe Kleinkort, PhD, PT for President, John Garzione, PT for Vice President, and Elaine Pomerantz, PT for Secretary. You will be receiving ballots in the mail, and we urge you return these.

I have immensely enjoyed serving you as President of the Pain SIG for the past 5 years. I now temporarily retire to the back row to watch with excitement the advances in pain management that will be presented to you over the coming years. Thank you very much to Bill Boissonnault, PT, DPT, MS, past president of the Orthopaedic Section for assisting us in formation of the Pain SIG, the Orthopaedic Section, and all of you who attended our CSM program. It has been a pleasure.

Tom Watson, PT, MEd, FAAPM
Past President of the Pain SIG

Too Good to Be True...Autonomic Modulation...Fact or Fiction

By Joe Kleinkort, PT, MA, PhD

> "The artist is nothing without the gift, but the gift is nothing without the work."
>
> Emile Zola (1840-1902)

Astonishing is a word that is not often used in the medical literature but even that word doesn't tell the story of promise for those with chronic intractable pain, especially those who suffer from CRPS (complex regional pain syndrome), formerly called reflex sympathetic dystrophy. There is a radically new modality now being released that will revolutionize the way this complex pain syndrome has been treated in the past. All practitioners who have dealt with this complex problem know of its devastating sequellae and moreover, the ramifications it has on mind, body, and soul! Finally there is a modality, STS, that can in over half the patients treated offer significant, if not total relief of the pain syndrome so that these patients can get on with a modulated exercise approach to return them to full function and enjoyment of life.

I have had the pleasure to evaluate the prototype model for the past 2 months on some of the patient with chronic pain I see in my "free" clinic. I can truly say that I have never seen such a dramatic response to any modality. Certainly there are some patients who don't respond but they are in the minority. I never expected such a revolutionary treatment when I initially wrote the chapter in *Therapeutic Medical Devices*.

The unit itself employs 8-paired channels to bombard the autonomic system in both the lumbar and cervical spine. A dermatomal placement of electrodes is critical to success depending upon the diagnosis. Usually when relief is enjoyed, it is from a few hours to over 24 hours and then the treatment is repeated. For optimal treatment, a 7-day protocol is preferred. After clinical success is established, the patient can be placed with a home unit and on a home program or clinical program of exercise to rehabilitate the loss of function. The results of the specific protocols are almost unbelievable in the chronic pain population.

In one study, Steven Sacks, MD, a physiatrist, looked at 70 patients treated with this modality, seeing an overall improvement in pain in 64% of the patients, a 50% decrease in use of medication, a 49% increase in sleep, and a 55% increase in activity. Two other studies are ongoing are with Lyn

Webster, MD on 30 patients with general chronic pain, and Ernesto Guido, MD on 20 patients with peripheral neuropathy. There are 3 studies that will get under way in March. The first is by Dr. Wagle, MD on patients with CRPS. Another is by Russ Foley, PT, MA on failed low back syndrome with 24 patients in the study. The last is by a physiatrist appointed by the Workers Comp Fund of Utah on 20 patients with chronic pain.

The most amazing results of this new modality are not just that it significantly modulates the pain far more than any modality we have experienced to date but also that it seems to immediately afford the patient far better sleep and increased ability for activity. This is truly a therapy that we all should keep our eyes on and will predictably alter the treatment of patients with chronic pain as we presently see them.

As the studies repeatedly show similar results, it appears that the chronic pain arena has been given a new life! We eagerly await the results of the ongoing studies and their efficacy. Those who are afflicted with chronic pain have a very promising modality on the forefront that may just alter the way we manage the patient with chronic pain forever.

CASE HISTORIES

Case History #1

Kathy is a 45 y.o. white female who has had a history of lifetime headaches primarily due to overheating, mainly occurring during the summer. She had had multiple workups to no avail. The headaches were severe in nature and were unrelieveable with any medication; they were cluster-like throughout the entire cranial region. They proceeded to get worse with age in both severity and longevity. The only thing that seemed to help was to wear a cooling collar. That collar allowed her to remain in a hot environment longer before the onset of headaches and caused the headaches to be less severe.

She was evaluated for the use of the STS machine and received the first treatment July 24, 2000. The upper extremity protocol was used #2 (brachioradialis, thumb, middle finger, little finger) for 40 minutes at an intensity of 25/25. Prior to the treatment, she had sustained a headache of an 8.0 on the Borg scale of pain due to overheating doing gardening work, and was unable to get rid of the headache. She did not take any medication this time and was placed on the machine about an hour after she sustained the headache. After about 20 minutes on the machine she reported a total negation of the headache. She continued to receive the treatment for a total of 40 minutes. After the treatment she was totally pain free. This was the first time she ever enjoyed the total negation of pain since she had the headaches in her entire life! She was amazed, as was the therapist.

The next day she did more yard work without her usual cooling collar and for the first time in her life didn't experience a return of her headache! She still received a second treatment the same as above prophylactically. There were no further treatments administered and she had no return of headache symptoms until January 15, 2001 when she worked out for over an hour. The pain was less than usual at a 5.0 and after 10 minutes of the above treatment she received total abolishment of symptoms and continued to receive the entire 40-minute treatment. She has continued to do the same workout regimen every other day since, with no return of headache symptoms.

This is unusual in that so few treatments abolished the symptoms and kept the symptoms from returning. This also has led me to see if there is the possibility that daily treatment is not necessary. In some of the cases I have evaluated since this patient, I have found that in some cases a day or two can be skipped and only slight decrease in efficacy has resulted. I also did not use magnets with this treatment and enjoyed the above results. This leads me to believe that the use of magnets with the treatment is not absolutely necessary.

Case History #2

Barb is a 63 y.o. white female who fell 4 years ago on her right arm and leg in a pile of rocks and developed chronic reflex sympathetic dystrophy, CRPS. She received various workups with multiple MRIs and various other diagnostic tests which all seemed to be negative. She continued to require stronger doses of medication to control her pain, but this wasn't helping. She finally went through a series of epidural blocks, which were only temporarily helpful with a subsequent return of pain in a few days. She also underwent regional blocks, which were of little assistance.

Overall she reported a 8.0 Borg scale of pain in her right upper and lower extremity with all the classical signs of reflex sympathetic dystrophy to include: shiny skin, hyperesthsia and decreased ROM of the lumber spine, cervical spine, and her right 4th and 5th digits were nonfunctional. Her quality of life was significantly reduced to being home bound. Her sleeping patterns were very poor due to pain, with inability to sleep an entire evening without pain and constant awakening. She was unable to place her shoes on by herself due to pain and significant decreased ROM of the lumbar spine with pain.

The first treatment was administered on December 3, 2000. The placement protocol #1 was used at 42 ch 1 and 38 ch 2. Before her treatment, her pain was a 7.0 in the right upper and lower extremity. After 40 minutes she reported a 0.0 in both areas with significant increase in her lumbar ROM such that she was able to painlessly put on her own shoe. She was as astonished, as was I! ROM in her lumbar spine had improved by about 50%. She also reported that evening was the "best sleep she had had in the last 4 years." She continued to receive the treatment daily, with about 8 hours of relief at first. After her sixth treatment, she was enjoying about a days relief. After 10 treatments, we also added 20 minutes upper extremity protocol #2 with enhanced relief of her shoulder and increasing ROM of her 4th and 5th finger ROM. The shininess of her skin reduced and her ADL significantly improved. After 20 treatments, she was placed on a home unit and started on a daily exercise regimen to increase her power and stamina. She remains painfree as long as she receives a daily treatment and even if she skips a day, only has a level 3 pain return. This regimen has totally changed her life back to the way she was before her accident. She has been off all medications for pain since the second treatment. The ROM in her 4th and 5th finger has returned 70% with function, and she enjoys full daily activities. She also has a severe case of intestinal scar tissue from numerous operations and has noticed a reduction of her overall symptoms from this as well.

Animal Physical Therapist

SPECIAL INTEREST GROUP

Orthopaedic Section, APTA, Inc.

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Orthopaedic Section Board Advisor
Lola Rosenbaum, PT, MHS, OCS

Orthopaedic Section Education Chair
Paul Howard, PT, PhD

SIG Coordinator and Off-Site Continuing Education Coordinator
Stefanie Snyder

CALENDAR OF EVENTS:

- The home study course **Basic Science for Animal Physical Therapists** is still available. Contact 800-444-3982 or 608-788-3982 for more information.
- The 2nd International Symposium on Rehabilitation and Physical Therapy in Veterinary Medicine will be hosted by the University of Tennessee College of Veterinary Medicine and the University of Tennessee at Chattanooga, Graduate Program in Physical Therapy in Knoxville, TN, USA. It is scheduled for August 10 - 14, 2002. To get on the mailing list either send an e-mail to: Conferences@utk.edu or call (865)974-0280. Website http://www.utc.edu/~vetpt/.
- The International course on Animal Physical Therapy is taking place in The Netherlands November 6 - 17, 2001. The first week is for dog and the second week is for horse. Housing and Transportation are provided. For information and registration forms please contact Cme@ipedier.hacom.nl or write to Anke Vaessen, Manager Dutch Education Animal Physical Therapy, Postbus 64, 3770 AB Barneveld, The Netherlands.
- The Florida Physical Therapy Association Board of Directors had a meeting in Orlando, Florida on Friday March 23rd to discuss the benefits and possible downfalls concerning the treatment of animals under our current practice act. A Task Force has been formed to represent those therapists interested in treating animals in the state of Florida. For more information contact Arlene White at (561) 575-0735 or email ArlyFAMU96@aol.com
- Canine Physical Therapy I: A 2-day course for Physical Therapists and Physical Therapist Assistants offered by the Oregon Chapter, American Physical Therapy Association. March 9-11, Portland OR. For more information, call Sandra Fischer at 877-452-4919 or email at: opta@teleport.com
- Canine Physical Therapy I (June 18-19, 2001): A 2-day preconference course for Physical Therapists and Physical Therapist Assistants immediately preceding the Annual Conference of the American Physical Therapy Association, (June 20-23, 2001) in Anaheim, California. For more information, contact David Levine at David-Levine@utc.edu. A separate session entitled: *Animal Physical Therapy—An Emerging Field* will be held during Annual Conference on Thursday, June 21st from 8:30-4:30.

Animal Physical Therapist Special Interest Group (APTSIG) Reports for CSM 2001 Orthopaedic Section, ATPA, Inc
President's Report - Cheryl Riegger-Krugh, PT, ScD

Summary of Business at the Combined Sections Meeting (CSM)

Several new members have joined as SIG officers, Committee Chairs and members, and state liaisons, and fortunately many officers remained. I thank all the officers, chairs of committees, and committee members, for their hard work and progress made this year. One new area of leadership includes the Practice Committee with Lin McGonagle, MSPT, LVT as Chair. Lin, the past president of the SIG, has graduated from veterinary technician school. She will be able to advise the SIG as to how holding dual training and degrees would affect ability to practice.

There are openings on a number of committees. If any member of the SIG is interested, please contact Cheryl Riegger-Krugh, as one of the openings is for Nominating Committee Chair. Another opening is the PTA representative. Thanks to Nancy Snyder, PT and Missy Folta, LPTA for their past service in these two capacities, respectively. Duties and responsibilities have been outlined for all offices and committee chair positions. This information can be shared with anyone interested in an office or committee and will be passed on to the new Nominating Committee Chair, when assumed by someone.

Nancy White, PT, MS, OCS, the liaison for the SIG to the Orthopaedic Section Board, attended the SIG Business Meeting, and was thanked for her excellent guidance. Nancy's term on the Board of Directors is completed and a new liaison for the SIG will be assigned. Bill Boissonnault, PT, MS, DPT, past president of the Orthopaedic Section, was thanked as well for excellent leadership to the Section and assistance to the Animal PT SIG.

The SIG encourages the development of a credentialing process that would be a collaborative effort between veterinary medicine and physical therapy for the purpose of establishing rehabilitation training for animal patients. This process is different from advanced clinical residency for human patients, as developed within the Orthopaedic Section, because the patients/clients are not human, some of the knowledge base is basic and not advanced, and the scope of practice for animal patients is not totally within the realm of orthopaedic practice. We believe these distinctions require a collaborative effort in the credentialing process. A planning group met at CSM to discuss a drafted outline of background information needed to define the scope of practice for animal physical therapy.

As part of the preparation for this process, several pilot residency experiences have occurred this year. One has included 1 week of clinical affiliation time provided within the context of the clinical affiliation weeks in a professional level master's degree program in physical therapy. Within that program, the affiliation week did not count toward the degree. Other pilot residencies have included designated on-site collaboration of a graduate PT interested in working with animals and a physical therapist who is providing rehabilitation for animals. The requests for residencies and affiliations far outweighs the ability to offer these experiences at present.

Liaisons have been established in many but not all states. A continuing goal to establish liaisons in all states. There has been a request to establish a committee composed of state liaison members for the purpose of coordinating and standardizing efforts to support wording in practice acts, which would legalize physical therapy practice for animals by physical therapists. The wording that is sought also would refer to the additional education required by physical therapists in order to treat animals.

The SIG has developed and continues to develop answers to frequently asked questions. These answers are initially published in the *Orthopaedic Physical Therapy Practice (OP)* newsletter, then are available for distribution by e-mail attachment from the SIG secretary to people asking these questions. These answers also will be made available to the Orthopaedic Section office for use when people call the office for the same information.

Canine One courses were presented in Knoxville, TN and Denver, CO in 2000. Canine Two and Equine One courses are being planned. The 2nd International Symposium for Rehabilitation and Physical Therapy in Veterinary Medicine is now scheduled for August, 2002 at the University of Tennessee at Chattanooga. Details and the official website will be available soon.

The Resource Manual has been developed and is being revised. This manual is available through Lin McGonagle.

The SIG continues to investigate and support the establishment of an International Animal PT organization through World Congress of Physical Therapy (WCPT). Before an international organization can be formed through WCPT, 6 countries must meet the criteria. At this time, we do not have enough member nations (6) that have formal animal PT groups to form a WCPT subgroup.

We encourage PTs interested in this field of practice with animals to join the APTA and the Orthopaedic Section. For the cost of purchasing the *OP* publication, an APTA member could join the Orthopaedic Section, become a full member of the SIG and have a subscription to this publication.

The SIG is encouraging use of outcome measures in intervention, as well as encouraging use of language used in the *Guide to Physical Therapist Practice*. The SIG also is encouraging use of meaningful outcomes, ie, outcomes that have functional significance for the functional limitations and disabilities of animals. At this time, PTs are encouraged to document outcomes for case studies as well as the studies with larger numbers of animals.

The SIG is pursuing an active liaison between the American Veterinary Medical Association (AVMA) and the APTA. This liaison is viewed as very important for our SIG, as we believe that the best way to proceed to develop the field of physical therapy for animals is a collaborative approach between veterinary and physical therapy.

Use of technology for communication, including information sharing on a website, is being investigated by our Education Chair, Kristinn Heinrichs.

There are 544 members of the SIG at this time.

SIG bylaws have been revised and are consistent with the guidelines of the Orthopaedic Section and the other SIGs in the Orthopaedic Section.

During this past year, the home study series in Basic Science for Animal Physical Therapists was completed. The series includes 3 monographs on Canine Antomy and Biomechanics and 3 monographs on Equine Anatomy. In addition to working with Darryl Millis, MS, DVM, and Joseph Weigel, DVM on the Canine Anatomy and Biomechanics home studies, I worked with on completing a chapter on Canine Anatomy for a textbook on canine rehabilitation and physical therapy.

Carrie Adamson, PT, MS, Robert Taylor, DVM, MS, DACVS, and I will be speaking at ACVIM, a veterinary conference focused on internal medicine, on Physical Therapy in Veterinary Patients in May 2001.

Vice-President's Report – David Levine, PT, PhD

Activities over 2000-2001:

The Home Study Course on Basic Science for Animal Physical Therapists occurred January – June 2000. I served as the Subject Matter Expert and worked with the authors in the preparation of the course.

A Canine PT I course was taught in Knoxville, TN by David Levine, PT, PhD, Darryl Millis, MS, DVM, Robert Taylor, MS, DVM, Joseph Weigel, DVM, Elizabeth Schull, DVM, Carrie Adamson, PT, MS, and Siri Hamilton, PT, LVT. Attendance was approximately 70 and course evaluations were extremely positive.

I gave a presentation at the 2000 American College of Veterinary Surgeons in which I mentioned the SIG and our efforts.

The formation of a WCPT group was investigated and it was determined that UK, Netherlands, the US, South Africa, and now Finland have formally established groups recognized by their parent organizations. As 6 member nations are needed, a WCPT is not feasible at this time, but we are moving closer.

I assisted the President in orienting new board members and chairs. I attended all of the SIG Executive Board Meetings and the Annual Business Meeting at CSM, assisted in the review and editing of the Newsletter, coordinated the annual survey of the membership, and reviewed the Policy and Procedure Manual.

Goals for 2001-2002:

- Teach Canine PT I and/or a Canine PT II course. Canine II tentatively will be taught in Knoxville, TN.
- Speak at the American College of Veterinary Surgeons meeting in Chicago and represent the SIG with highlights of our group.
- Speak at the North American Veterinary Conference in Orlando and represent the SIG with highlights of our group.
- The Second International Symposium on Rehabilitation and Physical Therapy is being planned for August 2002 in Knoxville, TN.
- Tabulate the yearly survey, and have it published in *OP* in 2001.
- Review the Policy and Procedure manual.

Secretary's Report - Stefanie Fagan, PT

I provided answers to "Frequently Asked Questions" from PTs across the country wanting to "get started" in rehabilitation for animals. Most interaction was done via email which averaged 1-2 replies per week and an occasional phone consultation averaging 1x/month.

I wrote an article for the first Wizard of Paws newsletter on "making the transition" to rehabilitation for animals.

I attended the American Veterinary Medical Association conference this summer in Salt Lake City. I mostly attended lectures concerning Alternative and Complementary Medicine. Speakers included Dr. Laurie McCauley (Postoperative Rehabilitation), Cheryl Schwartz (Clinical Indications for Homeopathy, An Herbal Approach to Skin Problems, and A Traditional Chinese Medicine Approach to Hip Dysplasia), Allen Schoen (Acupuncture in Veterinary Medicine), and Kevin Haussler (Chiropractic Evaluation and Treatment of Spinal Disorders). I also was lucky to "sneak" into the acupuncture wet lab one afternoon and learn about different points for hip dysplasia. My concern after attending this conference was the use of the word "physical therapy" to describe mostly modalities, ROM, and hydrotherapy. It was described as something a technician could do and there was very little mention of actually having a licensed PT perform this service! I found this quite disconcerting. We have more work to do in educating others about our profession.

I attended a course in Denver in early November called Introduction to Small Animal Acupressure. Instructors were Nancy Zidonis and Amy Snow, authors of *The Well Connected Dog*. I plan to write a review of the course for the newsletter.

I have been spending time with several different canine organizations in Salt Lake: Rocky Mountain Search and Rescue and the Northern Utah Retriever Club. I have been doing lectures on injury prevention, proper warm-up/cool-down, ways to stretch your dog, etc. I also have been going out on field trials with both groups to learn more about what is required for dogs during different activities.

Goals for 2001 include finishing the data base for small animal rehabilitation documentation.

This will be a generic evaluation, progress note, treatment flow sheet, etc. that can be used for documentation. I am inserting blank areas that can be customized to fit individual needs based on the therapist's background of knowledge and expertise, continuing education, use of manual techniques, etc.

I propose investigating some type of a chat group or something similar to discuss interesting cases over the internet.

Treasurer's Report – Nancy Murphy, PT

The budget has been completed.

Malpractice Insurance Committee Report from the Committee on Practice - Lin McGonagle, MSPT, LVT

Two malpractice insurance policies were investigated this year. An ongoing program with Van Zandt, Emrich and Carey of Louisville, KY has seen some activity in the form of inquiry and information gathering. A mock application was submitted for the company to review. Initial expenses were estimated at $60,000 with 4,000 policies needed to break even. The underwriting company did not feel that they could go forward with bringing this policy to market at this time.

The second company, Poulton Associates of Salt Lake City, Utah is ready to offer policies to physical therapists for hu-

man and animal malpractice coverage as well as equipment, general liability and property damage. The contact is Nona Florence at 801-268-2600, ext. 124. The mailing address is 3785 South 700 East #201, Salt Lake City, Utah 84106.

Jennifer Baker, from the APTA Insurance Department, submitted an article to the SIG newsletter relating to insurance issues with collaboration from David Levine and Lin McGonagle.

Goals for 2001 include investigating new policies that address animal rehabilitation and providing insurance coverage information to SIG members.

Newsletter Editor's Report – Arlene White, PT

I coordinated the information for the quarterly Animal PT SIG newsletter for 2000. The information was supplied by physical therapists who are actively pursuing careers in animal rehabilitation along with articles published in the Canadian Horse & Animal Physical Therapy Association's newsletter, and the South African Association of Physiotherapists in Animal Therapy newsletters.

I have had the opportunity to work with many passionate individuals who are dedicated to helping our animal friends. The opportunity to share knowledge through this medium continues to support the scientific basis regarding the use of physical therapy to improve function regardless of the patient. We have come a long way since the first newsletter in 1996, and I am sure we will continue to break new ground. It is an exciting time to be a physical therapist interested in rehabilitating animals as veterinarians and others are interested in learning about our services.

I am grateful to Cheryl, David, Kristinn, Siri, Stephanie, Rita, Lin, and the rest of you who have submitted articles and info for our newsletters. Your contributions are valuable and inspire those that are considering pursuing animal physical therapy as a career. I hope that 2001 will generate new contacts and that more people will get involved in providing information to share.

State Liaison Coordinator's Report – Siri Hamilton, PT

My report is a compiled listing on a spreadsheet with the contact information for liaisons for each state with a liaison. Please check the list and if your state does not have a liaison, please consider this position for your state. Liaisons are valuable, as often they are the closest contact geographically for someone interested in animal physical therapy.

CSM Programming Report – Kristin Heinrichs, PT-SCS, PhD, ATC/L, CSCS

The Animal Physical Therapist Special Interest Group held its annual business meeting and a very well-attended 4-hour education session at the recent Combined Sections Meeting in San Antonio, Texas. The 4-hour session consisted of an introduction to the principles of comparative anatomy, followed by concurrent sessions on canine anatomy and biomechanics (presented by Dr. Cheryl Riegger-Krugh, PT) and equine anatomy and biomechanics (presented by Ms. Arlene White, PT). The program continued with 6 platform case presentations:

The abstracts of these case presentations are posted at www.sportsperformance.org. In addition to the abstracts, valuable information regarding animal rehabilitation, continuing education courses, and discussion forums may be found on the website.

Review of Canine Acupressure Course

By Stephanie Fagin, PT

This was a 2-day course titled "Introducing Canine Acupressure" taught by Amy Snow and Nancy Zidonis, authors of the book, *The Well Connected Dog*. The course was held in Denver, Co, November 4th and 5th at a doggy daycare center called Doggy Pause. This course is the beginning of a 3-part series that eventually earns one certification in small animal acupressure. The focus of the course was to present an overview of traditional Chinese medicine and the history and theory behind acupressure and acupuncture. Day 1 covered the history, comparison to Western medicine, the concepts of Yin and Yang and basic meridian theory. They also covered basic treatment guidelines such as the pretreatment, opening, various point work techniques, and closing. I found Day 1 informative and it gave me a clearer understanding of the Chinese medicine theory and concepts and helped me to organize my thoughts when performing an evaluation from this perspective. Day 2 was a review of day 1 and an introduction to the 5-element theory, which I never really grasped, demonstrations of an acupressure treatment, learning new points, and case study reviews. There was ample time spent on practicing techniques, finding key points, etc. on many different types of dogs, but I felt that the lab time was somewhat fragmented and disorganized. Greater structure and more lab assistants would have been helpful and would have made the hands-on time more productive.

Another feature I found disconcerting was the lack of appropriate background in many of the "students" who attended. Very few had a medical background or knowledge of the anatomy of a dog or a human. I also felt that the instructors were indirectly encouraging the group to make decisions that were inappropriate for their scope of knowledge and without consultation with a veterinarian. Many of those attending the course were already practicing alternative therapies with animals practicing on their own accord without veterinary referral. I find this pretty scary, especially after listening to some of the case studies presented, many of which sounded like internal medicine issues that should not be placed in the hands of a lay-person.

All in all, I found the course informative and interesting and am curious about level II. Fortunately, I know my limitations and only hope that those without the appropriate background will seek knowledge on the basics (ie, anatomy, physiology, biomechanics, etc.), before they take more serious matters into their own hands. For more information on the course, contact: Tallgrass Animal Acupressure, 4559 W. Red Rock Dr., Larkspur, CO 80118 (303)-681-3033 acupressure4all@earthlink.net or www.animalacupressure.com

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2. Manuscripts should be reports of personal experiences and written as such. Though suggested reading lists are welcomed, references should otherwise be kept to a minimum with the exception of reviews of literature.
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4. Black and white photographs to accompany the texts should be glossy 5 x 7. A photo release form must accompany any photographs where patients may be seen. Digital photos are also acceptable. Any tables that might add to the usefulness of the article are also welcome.

IMPORTANT ANNOUNCEMENT FROM The American Academy of Orthopedic Manual Physical Therapists

At the request of the membership at-large the Academy will be re-opening the Fellowship challenge process by portfolio and examination. **This will be the final opportunity for individuals to challenge for fellowship before this window permanently closes next year.** After this point, only persons completing AAOMPT recognized manual therapy residency programs would be allowed to become Fellows of the AAOMPT.

Important dates to remember!

June 1, 2001:	
	Last day to submit letter of intent to challenge for Fellowship by practice portfolio and oral/practical examination
September 1, 2001:	
	Last day for submission of completed case studies and portfolio packets to AAOMPT for the first examination in February 2002
December 1, 2001	
	Letter of intent to sit for the **first** examination in February 2002 prior to the APTA Combined Sections Meeting or for the **second** examination in October 2002 at the AAOMPT Annual Conference
February 1, 2002:	
	Last day for submission of completed case studies and portfolio packets for second challenge examination in October 2002
February 2002:	
	First challenge oral/practical examination will be held in Cincinnati, prior to the APTA Combined Section Meeting.
October 2002:	
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For more information and details contact the Academy office at the following:

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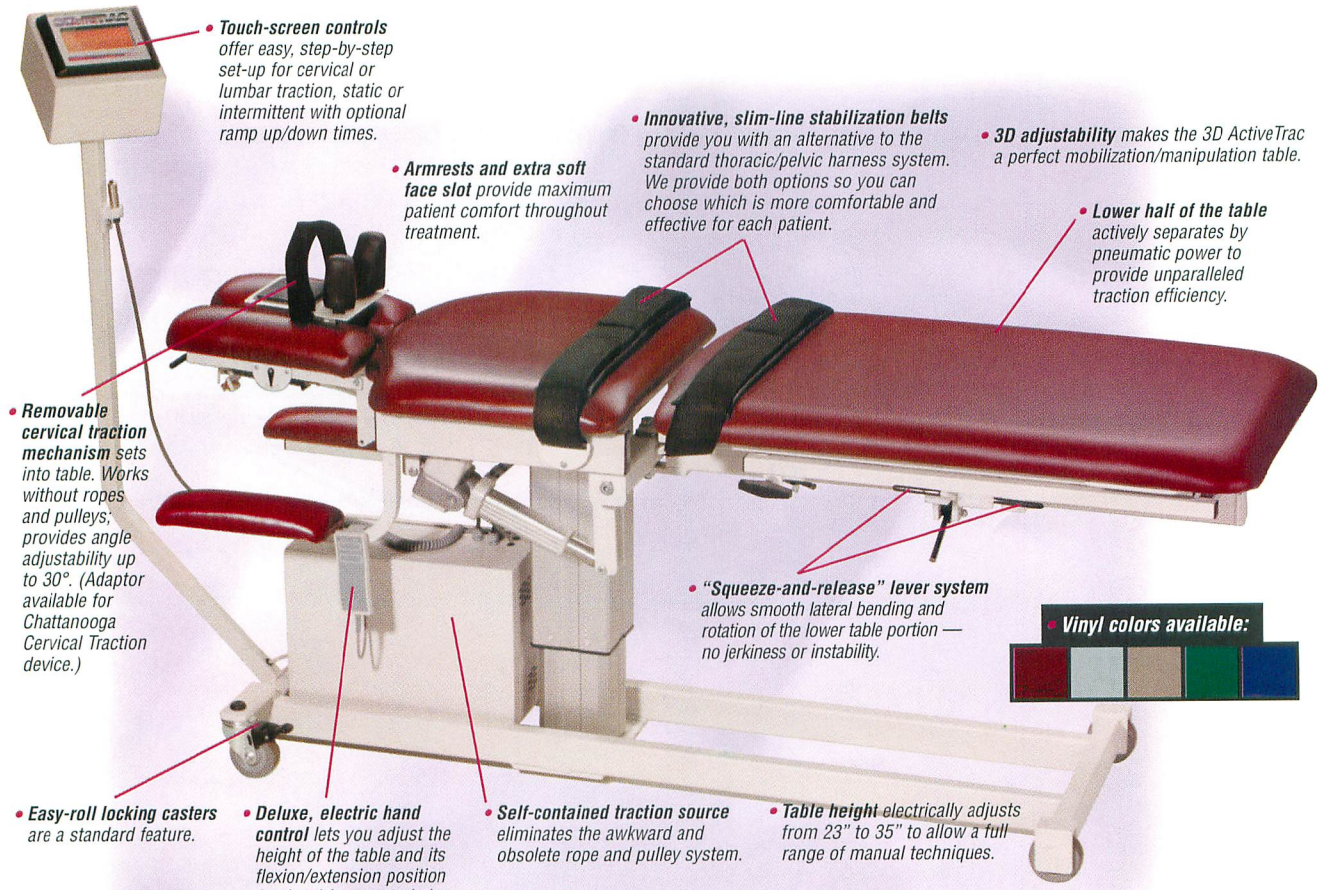

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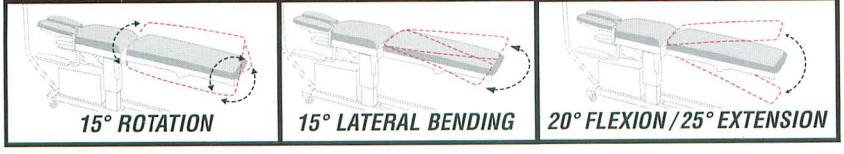

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