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Orthopaedic Physical Therapy Practice

AN OFFICIAL PUBLICATION OF THE
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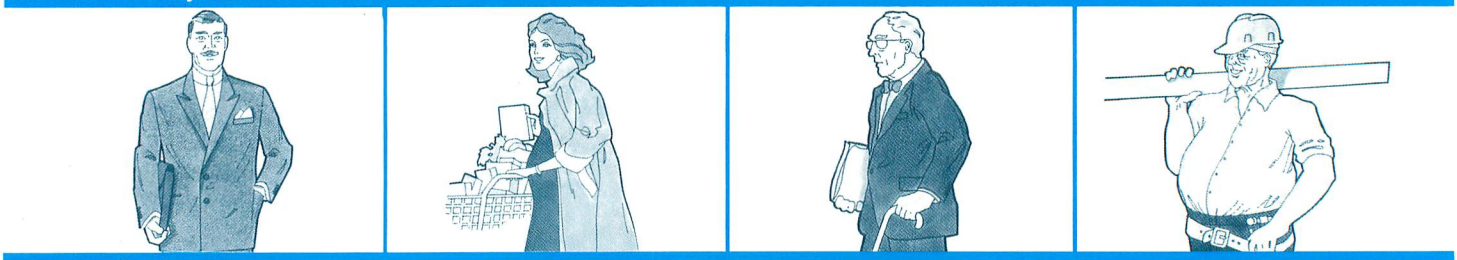

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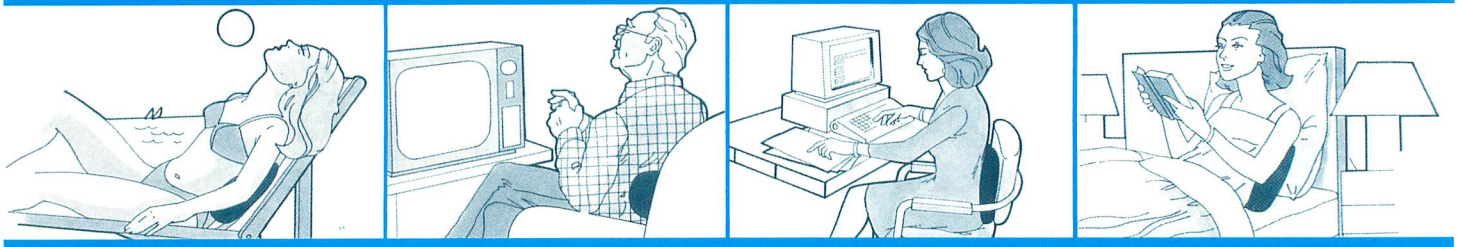

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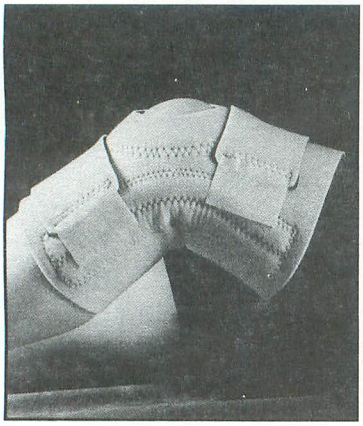

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Clay Vase with painted linen wrappings from the Tomb of Khai (C. 15th Century B.C.) emblazoned with the Eye of Horus sign, may have been the origin of the symbol Rx.

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Publications Committee Chair Commentary

The Place of the Solo and Small Group Private Physical Therapy Practice in the 90s

The 1980's were a decade of momentous change for the solo and small group physical therapy private practice. One major trend of the 80's was the emergence of the large group physical therapy practice.

The advent of the large group physical therapy practice can be traced to the cumulative effects of a series of events, most of them tied to changes in health care delivery and economics. For example, the solo and small group private practice of the 80's was faced with growing expenses from hiring staff to handling ever more complex billing and insurance claim procedures, marketing and competitive contracting arrangements.

While economic exigencies required sophisticated business expertise, a bewildering battery of legislative changes made already complicated Workers' Compensation and Medicare rules almost indecipherable. In addition, the growth of health maintenance organizations, preferred provider organizations and other managed care groups with their emphasis on cost containment measures had a major impact on solo and small group private physical therapy practice.

In the 80's, small groups and solo practitioners found that they could not always compete with large group physical therapy practices when negotiating contracts with managed care systems. Accountants and lawyers had to be added to the payroll in order to read and understand the small print in the contract.

Finally, some physical therapists were attempting to insulate themselves from the business issues of health care. By joining a large group practice, often a more cost effective approach to private practice, the physical therapist was willing to give up financial control in order to be insulated from the business realities and competitiveness of the health care market.

What will the 90's bring? Will solo and small group physical therapy practices survive and flourish the way they have in the past? Or, will they go the way of the dinosaur?

Having grown into a major player in the 80's, large group physical therapy practices almost certainly will further strengthen their position in the 90's. Clearly, the survival of the solo and small group practice depends on a skillful juggling act. A juggling act whereby quality patient care and documentation will have to be balanced by the complex, expensive and time consuming fiscal and procedural requirements imposed by medical economics and health care policy.

John M. Medeiros, P.T., Ph.D.

PRESIDENT'S MESSAGE

Jan K. Richardson, President

The Orthopaedic Section had a very successful program at CSM in Orlando, Florida in February. Attendance was the largest yet of any CSM to date. Congratulations goes out to Dr. Annette Iglarsh, PT and the Program Education Committee Members, Cynthia Driskell, Patricia King, Tracy Kirchner, Nancy White and Dan Riddle for the fine program that they developed again this year.

Additionally, the collaborative fund raising event that we shared with the Research Section was very successful. Saturday night the Orthopaedic and Research Sections held an Ice Cream Social with approximately 350 people in attendance. Ben and Jerry's ice cream was served in abundance while a D.J. played requests for our dancing pleasure. The ice cream was donated in total by Ben and Jerry's which will allow the Sections to donate a larger percentage of the proceeds to the P.T. Foundation for research activities. We extend our gratitude and thanks to Ben & Jerry's Ice Cream, APTA Meeting Services staff, the Research Section and our own Annette Iglarsh, PT, Terri Pericak, and Sharon Klinski for all of their time and energy which went into this event.

One of the highlights of the CSM meeting was the recognition of newly board certified specialists. Sixty-six P.T.'s received board certification of which 35 were certified in Orthopaedics. This now raises our total number of board specialists to 61 in the country. On behalf of the Orthopaedic Section we wish to extend our congratulations to these individuals and all past certified specialists in Orthopaedics and Cardiopulmonary, Electrophysiology, Neurology, Pediatrics and Sports.

We look forward to an equally productive meeting in Boston in June and encourage all of you to attend and support our Association while engaging in the congeniality that surrounds these programs.

Jan K. Richardson, P.T., Ph.D., OCS
President

FROM THE SECTION OFFICE

Terri A. Pericak, Administrative Director

The Section office has begun compiling a resource list of Orthopaedic Section members and their areas of specialization within orthopaedic physical therapy. The members on this list have given the Section approval to give out their name, address and phone number to persons requesting the expertise of a physical therapist. If you would like your name included on this list, please contact us. Our new 800 number is 800-444-3982. If you prefer to FAX your information, our FAX number is 608-784-3350.

CSM, 1991 in Orlando went extremely well. The Industrial Physical Therapy roundtable brought forth a motion to the membership at the Business meeting to be formally recognized as a special interest group of the Orthopaedic Section. The motion passed. Congratulations! We welcome you to the Orthopaedic Section. Anyone interested in becoming involved in this Special Interest Group should contact Sharon Klinski at the Section office.

The round table on Manual Therapy is also considering becoming a Special Interest Group of the Section. They will pursue discussion of this at Annual Conference.

The Section will be holding the "Review for Advanced Orthopaedic Competencies" in San Diego, July 21-27. Registration information is listed in this issue of *Orthopaedic Practice* and in *The Journal of Orthopaedic and Sports Physical Therapy*. We expect the course to fill up fast so get your registration in early! If you have any questions regarding this course, please contact Sandy LaValley at the Section office.

A home study course on the lower extremity will begin this fall. Kent Timm, P.T., Ph.D., A.T.C., SCS, OCS will be the editor. Watch for registration information in the next issue of *Orthopaedic Practice* and in *The Journal of Orthopaedic and Sports Physical Therapy*. If you have any questions regarding this course, please contact Sharon Klinski at the Section office.

Since January we have had a large increase in the number of student members to the Section. We attribute this in part to the new member mailing which was sent in December to all APTA members not presently Orthopaedic Section members.

The Executive Committee passed a motion at CSM to add a new membership category this year. The Section is now allowing academic Physical Therapy programs to join the Section at the student rate of $15 per school. Letters were sent to all PT programs. If you have any questions regarding this or your individual membership or would like more information on the Section, please contact Nancy Yeske at the Section office.

Orthopaedic Physical Therapy of the Lower Extremity Home Study Course

This will be a course beginning in September, 1991. The following is a list of chapter authors and their intended topics:

Kathryn Patla, P.T.	*"Kinetic Chain Effects"*
Karen Piegorsch, P.T.	*"Nerve Entrapment Lesions"*
Stan Guest, P.T.	*"Overuse Injuries"*
Gary Hunt, P.T.	*"Foot and Ankle Mechanics"*
Russell Woodman, P.T.	*"Cyriax Approach to the Hip"*
Paul Beattie, P.T.	*"The Cruciate Ligaments"*
Gordon Alderink, P.T.	*"Hip Mechanics"*

Call For Authors

Solicitation for other authors continues. If you are interested in writing a manuscript on the lower extremity, please contact Kent Timm at 517-771-6677 or the Section office at 1-800-444-3982.

PEER REVIEW ORGANIZATIONS

By Toni S. Walker, B.S., S.P.T., Graduate Student, School of Physical Therapy, Pacific University, 2043 College Way, Forest Grove, OR 97116

The cost of health care has caused those paying for health services to devise ways to control what has seemed to be an intractable acceleration in charges. Chief among payors trying to control costs has been the federal government which supports services for the needy under the state-related Medicaid program and provides a massive insurance program for the elderly under Medicare. Attempts at cost control have raised questions about effects on access to and the quality of heath care delivered under these programs. When enacting legislation to control costs through the use of a prospective payment system for inpatient expenses under Medicare, Congress responded to these concerns by creating utilization and quality control peer review organizations (PROs) as watchdogs against program and patient abuses.

Effective October 1, 1984, all hospitals wishing Medicare reimbursement had to contract with a PRO. PROs are state wide for-profit or not-for-profit organizations which have successfully negotiated contacts with the Department of Health and Human Services (DHHS).[7]

PROs were given responsibility for reviewing case histories, investigating patient or program abuses, and recommending sanctions (fines or exclusion from the program) against practitioners and providers who were determined to have "failed in a substantial number of cases substantially to comply with" or to have "grossly and flagrantly violated" obligations under the program.[5] Over the past few years PROs have been asked to focus on quality issues, and the number of sanctions recommended by PROs has become a concern among health care providers. While some groups complain PROs are not being aggressive enough, others argue that reviewing standards target unfairly rural and small town practitioners. The government maintains PROs do not function under sanction quotas.[3]

Health care providers' obligation under Medicare and sanctions for failure to comply with such are included under Section 1156 of the Social Security Act. Regulations for enforcing the provisions of the statute are incorporated in Part 1004 of Title 42 of the Code of Federal Regulation, and further instructions are supplied in the Peer Review Organization Manual (PRO Manual) developed by the Health Care Financing Administration (HCFA).[5]

Under Section 1156 of the Social Security Act, providers furnishing health care services under title XVIII of the Social Security Act, (i.e., the Medicare program) must assure: "that services or items ordered or provided . . .

(1) will be provided economically and only when, and to the extent, medically necessary;

(2) will be of quality which meets professionally recognized standards of health care;

(3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer organization in the exercise of its duties and responsibilities.[5]"

The act further provides for imposition of fines or excluding from the program providers who have:

"(A) failed in a substantial number of cases substantially to comply with any obligation . . ., or

(B) grossly and flagrantly violated any. . .obligation in one or more instances.[5]"

The statute provides for reasonable notice and opportunity for discussion between the provider and the PRO prior to the PRO's submitting a report and sanction recommendation to the Secretary of DHHS (i.e., via the Office of the Inspector General). Under the regulations, "substantial violation in a substantial number of cases" means a pattern of care has been provided that is inappropriate, unnecessary, or does not meet recognized professional standards of care, or is not supported by the necessary documentation of care as required by the PRO. "Gross and flagrant violation" is demonstrated by violation of an obligation occurring in one or more instances which presents an imminent danger to the health, safety or well-being of a Medicare beneficiary or places the beneficiary unnecessarily in high risk situations.[1]

The PRO sanction process is outlined briefly as follows. PROs may identify violations by examining a provider's practice, through case record reviews, or by referral from a PRO subcontractor, Medicare carrier or intermediary, HCFA or the OIG. If the PRO determines that the practitioner has committed substantial violations, an initial notice is sent giving the practitioner 20 days to provide additional information or request a meeting with the PRO. At this point the PRO and the provider may concur on a corrective action plan. After this period, if the PRO determined that substantial violations have occurred or in the first instance, if the PRO has determined that a gross and flagrant violation has occurred, a 30 days notice is sent out (i.e., the second notice in the case of substantial violations and the initial notice in the case of a gross and flagrant violation). The provider has 30 days to submit additional information to the PRO or to request a meeting. After this round, if the PRO determines that a gross and flagrant violation or substantial violations have occurred, it submits a sanction recommendation, and informs the practitioner she/he has 30 days to provide additional information to the OIG. In practice, the full PRO may make its determination on review of a recommendation made by a committee to which consideration of the case was delegated. There is no provision for a hearing at the OIG stage. The OIG has 120 days to act upon the PRO's recommendation. It may approve, reject, or modify the PRO's recommendation. In addition, for the exclusion sanctions, if the OIG takes no action by the 120 day deadline, the sanction becomes effective automatically. Under the statute, when the Secretary of DHHS (i.e., via the OIG) makes a determination to exclude a practitioner, the exclusion becomes effective upon reasonable notice to the public and the practitioner. Reasonable notice to the public is specified as publication in a newspaper of general circulation in the PRO area. In addition, the regulations provide for notification to the following entities at the OIG's discretion; originating PRO, PROs in adjacent areas, state Medicaid fraud control units, state licensing authorities, Medicare contractors and state agencies, hospitals, skilled nursing facilities, home health agencies, HMOs, medical societies and other professional organizations, Medicare carriers and intermediaries, health care prepayment plans, and other affected agencies and organizations. Post-determination administrative appeals include a hearing before an

administrative law judge (ALJ) and discretionary review by an administrative Appeals Council. Following administrative review, an unsuccessful party can appeal to the courts.[5]

Much controversy has centered on the procedures at the PRO stage concerning the implementation and public notice of sanction prior to administrative and judicial appeals. Practitioners complaints have included: at the PRO stage—lack of right to legal counsel, an evidentiary hearing, or opportunity to call defense witnesses or to cross-examine PRO witnesses, lack of sufficient information concerning the data used by the PRO in making its determination and inadequate time to prepare a response to the charges; at the OIG and sanction implementation stages—no provision for a hearing, implementation prior to completing administrative and judicial review, and harm resulting from publication of a sanction which would not be remediable at the appeals stage.[5]

Responding to mounting pressure from practitioners, the American Medical Association (AMA) instituted suit against the DHHS in April, 1987 asking for an injunction against further processing of sanctions until changes were made in the PRO process. In May 1987, the AMA, OIG, HCFA, and the American Association of Retired Persons (AARP) agreed upon the following improvements in the sanctions procedures: PRO letters notifying practitioners of violations will explain the identified problem, the facts relied upon, the importance of meeting with the PRO, and the potential results of a sanction. PROs will also insure that no member of a panel recommending a sanction to the OIG has personal bias against or is in direct economic competition with the subject health care provider.[5]

In addition to regulatory changes in the program, Congress and the courts became involved with attempts to improve the procedural fairness of the system. Once again, in 1987, as part of its annual budget reconciliation process, Congress amended the PRO provisions of the Social Security Act. A health professional from the PRO is now required to meet with medical and administrative staff of hospitals concerning the PRO's review of hospital services. The PRO is required to publish at least annually a report describing types of cases in which the PRO frequently found inappropriate or unnecessary care. The importance of educational activities (concerning the review process and criteria applied) is now emphasized among PRO function; and the PRO is required to take into account the problems associated with the delivery of care in remote, rural areas and other appropriate factors which could affect adversely the safety or effectiveness of treatment provided on an outpatient basis.[2]

The process that determines whether a provider is reimbursed for Medicare patients admitted to a hospital has several steps (Fig. 1). The hospital is granted the DRG-based reimbursement at the first step that finds the services rendered to be necessary. To determine whether services are necessary and are delivered in the appropriate setting, a Review Coordinator, usually a nurse paid by the PRO, makes regular visits to hospitals, reviews a sample of the Medicare admissions, and determines the appropriateness of admissions based on criteria that are part of the contract negotiated with the DHHS. Cases not meeting published admission criteria or those designated "outliers" (i.e., cases whose length of stay and/or visit exceed the mean by two standard deviations) are automatically referred to a PRO Physician Reviewer.[7]

The Physician Reviewer, who must have active staff privileges in at least one of the hospitals participating in the Medicare program in the PRO area, acts as a paid consultant for the PRO. The credentials of the reviewer may differ from those of the practitioner being reviewed, as there are no requirements regarding specialization or board certification.[7]

Unlike the Review Coordinator, the Physician Reviewer can exercise medical judgement regarding appropriateness of utilization independent of published criteria in reviewing a case. If he or she agrees that an admission is appropriate, the DRG rate for that patient's discharge diagnosis will be paid to the hospital in full. If the Physician Reviewer finds that an admission is unnecessary, the hospital is informed and given the opportunity to appeal this ruling. The Physician Reviewer is also free to identify a "quality of care" issue at this point, which may or may not be addressed by a separate panel. The third step of the utilization review process occurs if the hospital chooses to make a "reconsideration request." The case is then reviewed by a Physical Review Panel.[7]

In April 1989, the PRO program began operating under new federal rules that required review of outpatient procedures, home health care, nursing-home care, and care provided to active and retired military personnel and their families. The new rules, known as the "scope of work," represents a major expansion of the program beyond hospital-based care. Not only are reviews expanded beyond inpatient care, but PROs now review care provided to patients who are not Medicare beneficiaries.[3]

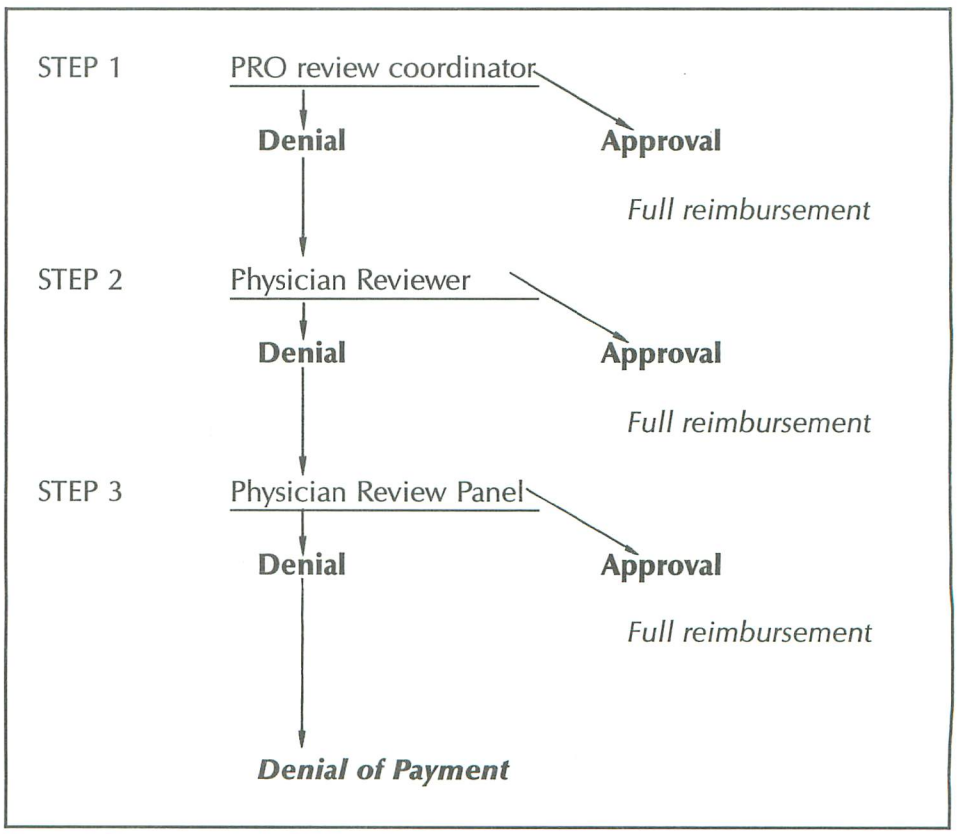

Figure 1. Summary of the PRO review process

For a federal program that many say is already overburdened, the expanded reviews have caused further financial and administrative confusion. Since the program's implementation in 1984, providers have complained steadily that the reviews are not timely, communication is poor, and the criteria for denying payment are hazy. The program, which succeeded the failed Professional Standards Review Organization program, was meant to instill greater accountability through performance- based contracts with measurable objectives.[3]

But hospitals in many states continue to report problems with their PROs. Florida, for example, is just one state where hospitals complain that review is being undertaken, and payment denied, for cases that were discharged more than two years ago. Hospitals in Idaho experienced a back log when their PRO's federal contract was picked up by Washington state's PRO. Retrospective payment denials have had a greater impact on the fragile finances of rural hospitals in those states than they have had on those of larger hospitals. When a small hospital gets denials from four or five years ago, it affects finances for that year.[6]

A common complaint is that the PROs do not communicate new review methods and instructions from the government thoroughly or quickly enough. When Texas' PRO declared that cardiac catheterization would be reimbursed only as an outpatient procedure, the policy was actually implemented before the hospitals were notified.[3]

Hospitals in New York report frustrations in dealing with their PRO—Empire State Medical, Scientific and Educational Foundation, Inc., Lake Success, NY. According to Judith Frangos, a vice-president with the Hospital Association of New York, the PRO does not bring the right people to meetings, does not bring written materials, and does not give good data.[3]

Policing those who provide health care is no easy task. What is good clinical practice must be determined under the unique circumstances presented by a given patient at a specific time. Translating good practice into standards and criteria for review by a third party is difficult at best; on a large scale the task may seem impossible. In addition, cost containment has become an important consideration in health care. It is vital that the quality of care is not compromised by the financial constraints imposed. Some form of peer review must be developed which is acceptable to practitioner and meets consumers needs. As is true for the Medicare program as a whole, the PRO program has undergone rapid, significant change and continues to evolve. Congress, HCFA, OIG, professional organizations, consumer groups, and the courts are working to make the program meet its dual objectives of protecting patients and treating health care providers fairly.

It is important for health care providers to become aware of the PRO process and what it means to their practice. It has become imperative that practitioners document the quality of care provided. The program will continue to change over the years, but one aspect will remain the same—an emphasis on examining quality of care.

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7. Whalen, J.P., Schmitt, B.P., & Rosseti, A.M. (1988, Jan/Feb). Early experience with peer review organizations. Journal of General Internal Medicine, pp. 59-63.

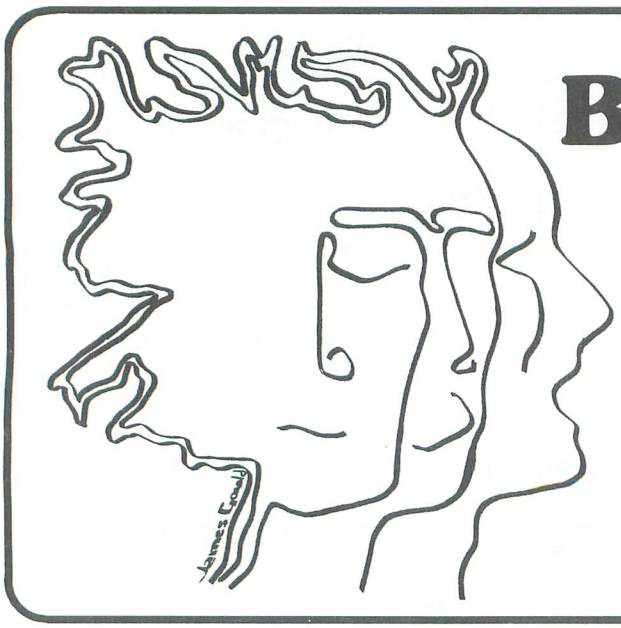
ANNUAL RAFFLE

Make sure you stop by the Section's new display booth at Annual Conference.

This year we will be raffling off a walkman (and a special unadvertised prize to be named at a later date).

As always, raffle tickets will be sold for only $1.00.

See you in Boston!



Become Involved!

ORTHOPAEDIC SECTION • AMERICAN PHYSICAL THERAPY ASSOCIATION • PRACTICE EDUCATION RESEARCH

1991
MASTER CALENDAR

January

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MAY

10 OP Mailing Date
17 JOSPT mailing date—June issue
20 DEADLINE—Ballots due to Section Office
27 HOLIDAY—Memorial Day

JUNE

17 JOSPT Mailing Date—July issue
21 7:30-10:00 Executive Committee Meets
10:00-12:00 Executive Committee & Chairs Meets
22 House of Delegates Meet
Annual Conference—Boston, MA
8:00-10:00 Industrial P.T. Business Meeting
10:00-11:00 Head & Neck Roundtable
11:00- 1:00 Manual Therapy Roundtable
23 House of Delegates Meet
Annual Conference—Boston, MA
8:00-10:00 Business Meeting
24 House of Delegates Meet
Annual Conference—Boston, MA
25 Annual Conference—Boston, MA
26 Annual Conference—Boston, MA
27 Annual Conference—Boston, MA

JULY

4 HOLIDAY—4th of July
19 JOSPT Mailing Date—August issue
21 Review For Advanced Orthopaedic Competencies Course
22 Review For Advanced Orthopaedic Competencies Course
23 Review For Advanced Orthopaedic Competencies Course
24 Review For Advanced Orthopaedic Competencies Course
25 Review For Advanced Orthopaedic Competencies Course
26 Review For Advanced Orthopaedic Competencies Course
27 Review For Advanced Orthopaedic Competencies Course
28 WCPT Meeting - London, England
29 WCPT Meeting - London, England
30 WCPT Meeting - London, England
31 WCPT Meeting - London, England

AUGUST

1 WCPT Meeting - London, England
2 WCPT Meeting - London, England
3 WCPT Meeting - London, England
15 DEADLINE—Applications to sit for 1992 Specialist Exam due to APTA
16 OP Mailing Date
19 JOSPT Mailing Date—September issue
22 COMMITTEE ON SECTIONS Meeting, APTA Headquarters
23 COMMITTEE ON SECTIONS Meeting, APTA Headquarters

July

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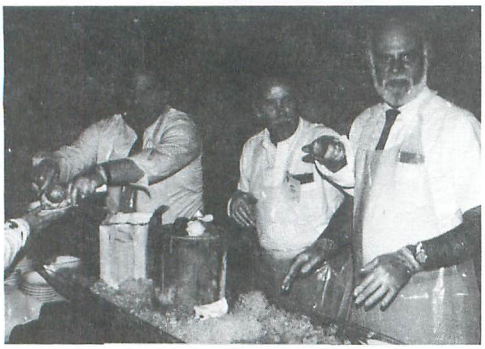
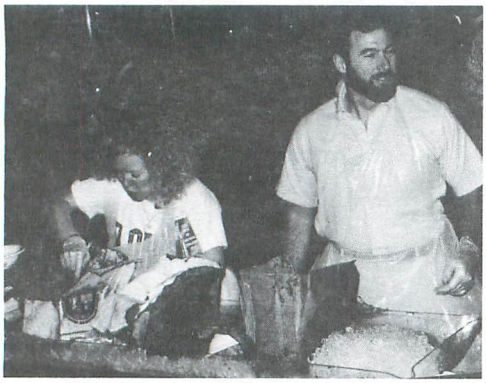
ICE CREAM EXTRAVAGANZA



Left to right: Jules Rostein, Jack Echtemach and Robert Lamb.

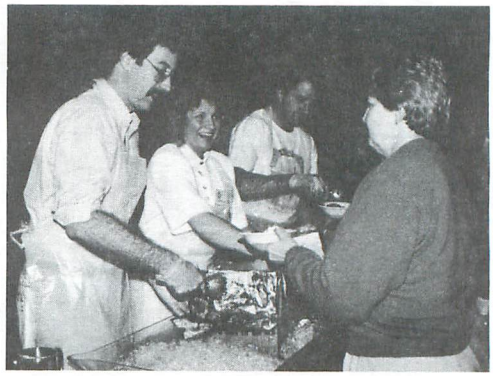


Betty Protas and David Krebs.

1991 CSM was the place. Saturday, February 3rd, was the date. All those with an insatiable appetite for ice cream gathered to partake in an all-you-can-eat ice cream feast. While officers of the Research and Orthopaedic Sections scooped up mounds of Ben & Jerry's ice cream to hungry PT's, a local DJ played hits from the 60's, 70's, and 80's.

This event was sponsored by the Research and Orthopaedic Sections of APTA with the ice cream being donated by Ben & Jerry's. All proceeds will be donated to The Foundation for Physical Therapy.

Duane Williams and Johns Wadsworth.



Left to right: Rick Reuss, Jan Richardson and Dan Riddle.

PRACTICE FORUM
Position Statement by Orthopaedic Surgeons on Direct Access

by: Practice Affairs Committee, Orthopaedic Section, APTA
Garvice G. Nicholson, P.T., OCS, Chair
William Boissonault, P.T.
Chauncey Farrell, P.T.
Donald Hiltz, P.T.
LTC. Jack W. Briley, P.T.

The term "independent practitioner" was skillfully chosen by the AAOS to place the focus on the physical therapist rather than on the patient. Physical therapists prefer to use the term "direct access" which implies the patient has a choice about whether to go directly to a physical therapist or to some other practitioner first. The autonomy of the physical therapist is at issue and potentially enhanced by direct access. However, the freedom of choice and health care costs for the consumer should not be overlooked.

During 1990, no additional states achieved direct access privileges in their state P.T. practice acts. Did actions such as this one by AAOS have a significant impact on our legislative attempts? The answer would seem an obvious yes given the size and prestige of such an organization as AAOS and the abrupt halting of the trend of successes recorded in 1989. Also, the rippling effect on other major physician groups should be considered. What has surprised us is the lack of awareness among physical therapists of this action taken by AAOS. We felt it important that physical therapists should be made aware of such actions in order to effectively deal with such attitudes at the local and national level.

Members of the Practice Affairs Committee provided their personal responses to the position statement and are summarized as follows:

In December of 1989, the American Academy of Orthopaedic Surgeons ratified the following position statement:

"Independent Practitioner Status for Physical Therapists"

The American Academy of Orthopaedic Surgeons believes that the best interests of the musculoskeletal patient are served through a process that ensures a thorough initial diagnostic evaluation performed by a licensed physician, with careful referral for ancillary services.

The important role of physical therapy in the treatment of musculoskeletal conditions is enhanced by cooperation among physicians, therapists, and patients. The Academy believes that the omission of a diagnostic consultation with a licensed physician places the patient at an unacceptable risk and threatens the quality of care for musculoskeletal disorders. Physical therapists are not trained in the complex task of medical diagnosis, nor do they have available to them the tests and equipment requisite for comprehensive evaluation; independent physical therapists may thus begin physical therapy with a patient whose underlying disease is critical and warrants immediate medical attention. In cases such as these, forgoing an initial consultation with a physician may delay appropriate treatment or postpone it indefinitely, resulting in a serious erosion of quality of care.

The Academy believes that independent practitioner status for physical therapists may increase health care costs. The mishandling of patient complaints resulting from inadequate diagnosis may contribute to increased and prolonged medical or surgical costs, in addition to costs already incurred for unnecessary or inappropriate physical therapy. In addition, independent practitioner status may lead to an increase in liability insurance premiums for physical therapists, with costs passed on to patients and payers.

Physical therapy plays an important role in the amelioration of many musculoskeletal complaints. The American Academy of Orthopaedic Surgeons believes that optimal patient care can best be achieved through the cooperative efforts of the patient's physician and the allied services that he or she deems appropriate based on a complete diagnosis.

The Academy is opposed to independent practitioner status for physical therapists, because the failure to consult initially with an orthopaedic surgeon or other physician may result in improper diagnosis, delay in appropriate treatment, and additional medical risks and costs.

From: LTC Jack W. Briley, M.A., P.T.
Chief, Physical Therapist
Ireland Army Hospital
Fort Knox, KY 40121

Thanks for giving me the chance to share my experiences and opinion. Please realize that the following is my personal and professional position and doesn't reflect official statement from the Department of the Army.

However, Army physical therapists have been credentialed to perform independent musculoskeletal evaluations (MSE) since 1974. Before these privileges/credentials were extended special courses were attended and a period of supervised "internship" was completed before full independent credentials were extended. These same type of courses are available to the civilian sector and, in fact, many military P.T.'s used civilian courses for beginning and advanced studies in conjunction with military sponsored courses.

In fiscal year 1988, 1,128,154 visits were made to Army P.T. clinics with 120,527 musculoskeletal evaluations performed. In fiscal year 1989, 1,123,072 total visits were made to Army P.T. clinics with 131,251 musculoskeletal evaluations performed. So far this year 99,972 MSE's have been performed by Army P.T.'s. In the 16 years that Army P.T.'s have been doing musculoskeletal evaluations, no Army P.T. has been sued or lost clinical privileges for "mishandling of patient complaints", or "unnecessary or inappropriate physical therapy".

An important position must be realized. The SCOPE in which Physical Therapists' practice their skills does not change with independent practice. For nearly 23 years as a P.T., I and other P.T.'s have received consults from licensed physicians stating "Evaluate and Treat" with unclear diagnoses such as shoulder pain, LBP, or knee pain. This is a very

clear indication that licensed physicians have confidence in P.T.'s evaluating and treating musculoskeletal patients without supervision. It is the P.T. that provides the definitive diagnosis of external rotator cuff tendonitis, PVM strain or patellofemoral pain syndrome. With the recent public awareness of physical therapy and the skills they possess and injuries they successfully treat, many patients with simple musculoskeletal injuries want to be seen by Physical Therapists. However, in many states they have to bear the cost of an office call to a physician just to get the consult adding to the total cost of medical care.

Acting as musculoskeletal evaluators, Army P.T.'s have provided extra time for the Orthopaedic Service to concentrate their efforts and time with surgical patients and fracture treatments. Based on the length of time these successful programs have been in existence, the success of physical therapists making accurate identification of musculoskeletal conditions, and the support of the various Orthopaedic Services for P.T.'s to continue to provide this service, the question of independent practice is not the real issue, but lost revenue.

In the Army, the Orthopaedic Service is part of the P.T. Clinic's QA chain making monthly audits of our evaluations. Their only comments are usually in reference to terminology. If there had, at any point in the past 16 years, been any doubt of Physical Therapists' ability to perform independent musculoskeletal evaluation and treatments the Army's program would have been terminated long ago. This is not a professional issue, but one of money.

From: William Boissonault, M.S., P.T.
2800 Chicago Avenue S., Suite 200
Minneapolis, MN 55407

I received and read with interest your memorandum and accompanying document put out by the American Academy of Orthopaedic Surgeons. Their concerns and complaints about the independent status for physical therapists sounds very familiar. We have heard all this rhetoric during our legislative fight for direct access here in Minnesota.

The bottom line regarding all their concerns is that there is absolutely no proof, no published data, that supports any of their concerns. For instance, in the second paragraph of the document the statement says, "The Academy believes that the omission of a diagnostic consultation with a licensed physician places the patient at an unacceptable risk and threatens the quality of care for musculoskeletal disorders." It is my understanding that Maginnis and Associates has published information showing that there has been absolutely no increase in the number of malpractice claims against physical therapists in states that have direct access. Their next statement in that paragraph, "Physical therapists are not trained in the complex task of medical diagnosis"; is absolutely true. It is beyond the scope of physical therapy to evaluate and formulate a medical diagnosis, but physical therapists do receive training to screen for the presence of medical disease in a general sense. I do feel we have the clinical skills to make a decision regarding whether the patient's problem is one that will respond to physical therapy or not. If we are suspicious at all that the problem is not of the type that will respond to physical therapy, we then refer the patient to a physician to do the appropriate medical examination and implement the subsequent treatment. Again, there is absolutely no proof documented anywhere that patients are at a higher risk when seen initially by a physical therapist.

In the third paragraph of the document there is a statement that reads, "The Academy believes that independent practitioner status for physical therapists may increase health care costs." Again, there is no proof showing that the cost for physical therapy care has risen in states with direct access. In fact, data from a 1989 national random sample of 1125 patients found that charges per episode of care among P.T. private practitioners were 2% less in states allowing direct access compared to those that did not. This combined with additional physician office visits required in states restricting direct access refutes the AAOS position concerning potential increased costs.

Regarding the fourth paragraph, I fully support the American Academy of Orthopaedic Surgeons statement that optimal patient care can best be achieved through cooperative efforts by the patient's physician and the allied services. The advent of direct access does not necessarily imply that there will no longer be a cooperative effort between physician and physical therapy professionals. It is my opinion that direct access will enhance the cooperative efforts between our two professions as opposed to impeding them.

As I mentioned earlier, all of the concerns raised by the American Academy of Orthopaedic Surgeons we have heard over and over in the state of Minnesota. I cannot emphasize enough that there is absolutely no data to support any of their concerns or complaints related to changes in the health care system due to direct access for physical therapy.

From: Donald L. Hiltz, P.T.
601 South Fourth Street
Suite B
Gadsden, Alabama 35901

Thank you for allowing me to peruse and comment upon the Position Statement of The American Academy of Orthopaedic Surgeons.

The entire argument against direct access can be refuted easily. In this litigious climate, it is abundantly clear that the slightest mistake on the part of any medical practitioner will precipitate a lawsuit. This unfortunately, has become a fact of life. Notwithstanding this, statistics from our two largest malpractice carriers constantly show no increase in the number of suits filed against physical therapists in direct access states (22).

If indeed patients were being treated in an inappropriate manner, or treatment were delayed, it is inherently obvious that there would be a marked increase in malpractice suits. Aggressive, zealous attorneys would be only too happy to seize upon a situation in which they could profit from alleged inferior care. Orthopaedic surgeons are particularly cognizant of this.

The bottom line is that the dollars and cents issue would clearly show itself if physical therapists were not performing well as "independent practitioners".

From: Chauncey E. Farrell, M.S., P.T.
5533 Summers Lane
Klamath Falls, Oregon 97603

The insistence of the Academy's position on a specific medical diagnosis is questionable. Spratt et al (Spine Vol. 15, #2, 1990) states a precise diagnosis is unknown in 80—90% of patients suffering disabling low back pain. Further, Spratt et al showed equivalent quality of reliable information from the physical examinations performed by physician and non-physician examiners.

The risks in terms of disability and increased costs associated with unnecessary surgeries performed on the lower back are very high. Saal and Saal (Spine Vol. 14, #4, 1989) and Saal et al (Spine Vol. 15, #7, 1989), both reported favorable outcomes with non-operative treatment of lumbar disc problems, a condition once thought to be amenable only to surgery. Physical therapists are well qualified to examine patients with mechanical musculoskeletal problems and determine their appropriateness for conservative management.

The Orthopaedic Section is interested in the members' concerns and experiences with this issue. Please address your letters to: Orthopaedic Section, APTA.
ATTN: Garvice G. Nicholson, PT, OCS
505 King Street, Suite 103
La Crosse, WI 54601

MANUAL THERAPY ROUNDTABLE

The Manual Therapy Roundtable was chaired by Stanley V. Paris, Ph.D., P.T. Dr. Paris divided the forum up into two parts. The first part was a presentation on the history, philosophy and definition of manual therapy as well as a discussion regarding different assessment and treatment approaches to patient care. The second part was a round table discussion on practice issues, organization structure of manual therapy associations and whether or not a special interest group of The Orthopaedic Section, in manual therapy should be formed in the future.

The discussion ranged broadly, and Dr. Paris encouraged audience participation. The conventional wisdom is that skilled passive movements of joints have always been a part of physical therapy. Most joint problems have more than one diagnosis and mobilization and manipulation are both assessment and treatment techniques.

This is just a summary of the highlights of the Manual Therapy Roundtable. It was decided that a special interest group in manual therapy may be formed at the Combined Sections Meeting next year. At that meeting, officers may be appointed.

Submitted by
John M. Medeiros, P.T., Ph.D.

ROSE EXCELLENCE IN RESEARCH AWARD RECIPEINTS

Jack DiVeta, M.S., P.T., "pictured in the center" was the '91 recipient of the Rose Excellence in Research Award. Jack and his co-authors, Martha L. Walker, M.S., P.T. and Bernard Skibinski, M.S., P.T., were all present to receive their awards at the 1991 Combined Sections Meeting in Orlando, Florida. The title of these researchers' paper was "Relationship Between Performance of Selected Scapular Muscles and Scapular Abduction in Standing Subjects." The paper was published in the August, 1990 issue of *Physical Therapy.*

Congratulations to all those Orthopaedic Certified Specialists who received their certificates at the Combined Sections Meeting in Orlando, Florida.

MEETING MINUTES

FEBRUARY 2, 1991
MARRIOTT ORLANDO WORLD CENTER
AGENDA

CALL TO ORDER AND WELCOME—9:00 AM

The Business Meeting was called to order at 9:00 AM by President, Jan Richardson, P.T., Ph.D., OCS.

PRESIDENT'S REPORT

Jan K. Richardson, P.T., PH.D., OCS

A. Approve Membership Meeting Minutes (June, 1990, Anaheim, CA) =MOTION= To approve the Business Meeting minutes as published and corrected. =PASSED=

B. Review and Accept Agenda =MOTION= To approve and accept the agenda as printed. =PASSED=

C. Review of Meeting Procedures
- Format of Meeting
- Motion Forms

EXECUTIVE COMMITTEE REPORTS

Vice-President—Duane Williams, P.T., M.A.

The results of the Fred Pryor Seminars survey and Membership survey were reviewed. The needs of the membership in terms of what the Section should be involved in matched with those outlined at the Fall Executive Committee Meeting, i.e. more research and educational programming, organization of special interest groups via roundtables, etc.

Treasurer—John Wadsworth, M.A., P.T.

An overview of the 1991 budget was presented. A Reserve Fund has been implemented with a current balance of approximately $49,000, which is less than 10% of one year's operating expenses. The Section's goal is to have at least 50% of one year's operating expenses in a reserve fund. An Equipment Reserve Fund has also been implemented, which will serve to cover future equipment purchases, and a Miscellaneous Fund was developed for unexpected expenses which may occur during 1991.

The unaudited financial statements for the 1990 year end shows the Section approximately $6,000 in the black. After applying final accrual adjustments for 1990, we hope to end up close to a balanced budget.

Member-At-Large—Rick Reuss, P.T.

Emphasis was placed on updating the Section Bylaws. The amended Bylaws will be printed in the ballot to be voted on by the membership.

Education Program Chair—Annette Iglarsh, P.T., Ph.D.

Programming for the 1991 Combined Sections Meeting included three hours of roundtable discussion for Industrial Physical Therapy and Foot and Ankle Physical Therapy and two hours for Manual Therapy and Head and Neck Physical Therapy. Everyone was encouraged to attend the Ice Cream Extravaganza sponsored by the Orthopaedic and Research Sections. The ice cream was donated by Ben & Jerry's. All proceeds will be given to The Foundation for Physical Therapy.

Research Chair—Dan Riddle, M.S., P.T.

The Rose Excellence in Research Award was established in 1988 in honor of the late Dr. Steven J. Rose. This award recognizes the author and co-authors of a published study which the Research Committee feels made the greatest contribution to the science and practice of orthopaedic physical therapy. On behalf of the Orthopaedic Section, plaques were presented to the 1991 recipient, Jack DiVeta, M.S., P.T.; and co-authors, Bernard Skibinski, M.S., P.T.; and Martha L. Walker, M.S., P.T. Their paper, published August, 1990, in *Physical Therapy* was entitled, "Relationship Between Performance of Selected Scapular Muscles and Scapular Abduction in Standing Subjects".

JOSPT Editor—Gary Smidt, P.T., Ph.D., FAPTA

The Journal office moved from La Crosse to the Medical Campus at the University of Iowa, where a Managing Editor and support staff have been hired. The quality of the Journal will continue to increase based on more papers submitted and recruiting additional reviewers in various areas of expertise. A change in the design of the Journal cover is planned for July. Williams and Wilkins will also be implementing a change, due to the decrease in revenues over the last year. They will place advertisements between articles on a "trial run" basis to see if it will have a positive impact on revenues.

Administrative Director—Terri Pericak

The following staff changes have occurred this past year: Sharon Klinski, Publications Coordinator, is responsible for our quarterly publication, *Orthopaedic Physical Therapy Practice,* as well as the Geriatric Section's publication, *Geritopics.* Nancy Yeske was hired in October as the new Membership Secretary. She was able to streamline membership services making it more efficient. Sandy LaValley was hired in August as a secretary/receptionist. She has been extremely helpful in picking up loose ends thus enabling the office to become more organized.

The Section now has a new 800 number: 800-444-3982. Our Fax number is 608-784-3350.

Those in attendance were encouraged to stop by the new booth. An attendance sheet was passed around and people were encouraged to volunteer to serve on a committee and become involved in the Section.

PROGRAM REPORTS

Membership—Terri Pericak, Administrative Director

Nancy Yeske, Membership Secretary, has been sending out welcome packets to new members weekly. APTA implemented a new policy whereby they would send the components weekly labels of new members who just joined the Section. Labels were previously sent once a month.

A membership survey was distributed to a random sampling of members requesting information and opinions on demographics, publications, section services, public relations, conferences and meetings, and general section interest. The results will aid the Executive Committee in future planning for the Section.

There was an increase in sales of competencies manual in the last month. We hope this is a good indication that we will have a large registration for the Review Course in July, as well as a large number of people applying to sit for the specialty exam in 1992.

The Orthopaedic Section membership applications were updated and mailed prior to CSM to all APTA members not currently Orthopaedic Section members.

Education Program—Annette Iglarsh, P.T., Ph.D.

The Education Program Committee is expanding its activities to help meet the needs of the Executive Committee. A Home Study Program on the Lower Extremity is planned with Kent Timm, P.T., Ph.D., ATC, SCS, OCS, as Editor.

The "Review for Advanced Orthopaedic Competencies" Course date has been changed to July to allow registrants time to prepare for the August 15 exam application deadline. An Orthopaedic Section Two Day Program is scheduled for Friday and Saturday, July 26 and 27, to allow local physical therapists to attend. There will also be a luncheon followed by a business meeting on Friday, July 26. We hope to get 5 or 6 publishers to exhibit to help offset the cost of the course.

The Canadian/American Orthopaedic joint meetings are scheduled for 1994 in Toronto and 1996 in Florida.

Publications—John Medeiros, P.T., Ph.D.

Sharon Klinski, Publications Coordinator, was thanked for all her work on *Orthopaedic Practice*. A change in the design/layout will be implemented this year. The cover will feature a different historical picture each issue relating to physical therapy. The membership is encouraged to submit case studies, general review papers, etc.

Research—Dan Riddle, M.S., P.T.

A brief overview was given of the platform and poster presentations scheduled for 1991 CSM. Attendance to these presentations was encouraged to support fellow Section members.

Specialization—Rick Ritter, M.A., P.T.

Rick Ritter will become the new chair of The Orthopaedic Specialty Council in June. Susan Stralka, P.T., will rotate off in 1992. Those replacing these council members will be certified specialists. The goal is to have the entire council made up of orthopaedic certified specialists.

The Specialty Exam has been given 3 times. This year's goal is to incorporate a lot of the documentation presently asked for on the application into the exam.

Finance—John Wadsworth, M.A., P.T.

The Finance Committee will meet in June to develop financial guidelines for daily operations, as well as for investments. The committee will also start planning the 1992 budget at this time.

Practice Affairs—Garvice Nicholson, M.S., P.T., OCS

The Position Statement on Manipulation was discussed and then deferred to New Business. A brief history of the AAOS' Position Statement on Direct Access was given. In December, 1989, the AAOS adopted a position that was worded in opposition to independent practitioners with the status of P.T. This turned the focus on physical therapists as independent practitioners rather than direct access which focuses on the consumer. The Practice Affairs Committee has prepared a response that will be published in *OP* and will ask members for their opinion on the issue.

Public Relations—Jonathan Cooperman, M.S., P.T.

Those in attendance were encouraged to visit the new booth and take a look at the new photographs displayed. The committee is presently working on the raffle for Annual Conference.

Nominating Committee—Scott Hasson, Ed.D., P.T., FACSM

Discussion included concerns of the balloting procedures which requires the member's name on the returned ballot. The committee would appreciate any member's suggestions on an alternative to this method. Nominations were requested from the floor for the offices of Member-At-Large and Nominating Committee Member. None were brought forth. The slate for the above positions is:

Member-At-Large
Nancy Byl, Ph.D., P.T.
Michael Cibulka, M.S., P.T.
Stanley Paris, Ph.D., P.T.

Nominating Committee Member
Courtney Bryan, P.T.
Gary Smith, Ed.D., P.T.
Susan Stralka, P.T.

The official ballot will be mailed to all members on April 15th.

UNFINISHED BUSINESS

Approve 1991 Strategic Plan and Budget

This was officially approved at the Executive Committee Meeting during CSM. A summary of the budget will be published in *OP*.

Fall Meeting, 1991

The 1991 Fall Meeting is scheduled for October 3-6, in Pittsburgh, Pennsylvania.

NEW BUSINESS

Life Members

Jan Richardson, P.T., Ph.D., OCS, gave a brief history on the topic of life members within Sections. Presently, there are 120 life members. The expense to the Section is $6,185.00 per year for these life members. It was reported that a motion is coming forth to the House of Delegates specifying whether the Sections should levy or not levy dues to life members.

Position Statement on Manipulation

Two motions, one by Garvice Nicholson, M.S., P.T., OCS, the second by Jerry Fogle, M.S., P.T., to amend the position statement were passed. The final position statement now reads:

=MOTION= The Orthopaedic Section, APTA, recognizes the manipulative techniques by licensed physical therapists in evaluation and treatment of individuals with musculoskeletal dysfunctions has been an integral component within the scope of practice of physical therapy since it's inception.

The following guidelines are further offered:

1. Manipulation in all of its forms is within the scope of practice of the licensed physical therapist.
2. The force, amplitude, direction, duration and frequency of manipulative treatment movements is a discretionary decision made by the physical therapist on the basis of education and clinical experience and on the patient's clinical profile.
3. Manipulations implies a variety of manual techniques which is not exclusive to any specific profession. =PASSED=

=MOTION= Susan Isernhagen, P.T., moved that the Executive committee acknowledge the petition of the Industrial Roundtable to be recognized as a Special Interest Group in the Orthopaedic Section effective as soon as possible—with the name of the Special Interest Group to be selected at a later date. =PASSED=

A clarification was given as to whether or not the Paris Founders Award and the Distinguished Service Lecture Award are two separate awards. Jan Richardson, P.T., Ph.D., OCS, explained they are the same award. It was given out for the first time last year to Stanley Paris as the original founder of the Section.

=MOTION= Motion made by Trish King, P.T., that the Distinguished Service Award be clearly named "The Paris Distinguished Service Award." =PASSED=

SECTION NEWS

VICE PRESIDENT

NARRATIVE SUMMARY OF PRELIMINARY MEMBERSHIP SURVEY, DECEMBER, 1990

Nancy Yeske, Section Membership Secretary, sent out a preliminary sample survey to 149 individuals. The survey was sent out to three groups and the returns are summarized below:

	Sent	Returns
Random Sample of Orthopaedic Section Membership	50	17
All Orthopaedic Certified Specialists	61	40
Industrial and/or Podiatric Special Interest Members	38	17
TOTAL	149	74

Demographics

Sex: 42 males, 32 females

Ages: 1 (18-25); 35 (26-35); 30 (36-45); 7 (46-55); 1 (55 or older)

Years of Practice: 6 (2-5 yrs.); 19 (6-10 yrs.); 49 (more than 10 yrs.)

Employment Status: 38 full-time salaried; 29 full-time self-employed; 7 others.

Primary Position: 16 owners of practice; 20 partners in practice; 11 Directors; 11 clinical staff; 7 faculty; 8 misc.

Work settings and percentage of time in different activities were quite varied.

Education Level:

5 doctorate; 19 advanced masters; 5 entry-level masters; 9 post-baccalaureate certificates; 36 bachelors.

Publications

Seventy-eight percent of the respondents indicate they read some of *The Journal of Orthopaedic and Sports Physical Therapy (JOSPT)* and *Orthopaedic Physical Therapy Practice (OP)*. Sixty-four percent keep *JOSPT* and 41 percent keep *OP* as a personal reference. The majority of respondents felt *JOSPT* gave balanced coverage to different topics. Twenty-six respondents felt *OP* should cover more regional news affecting orthopaedic physical therapists.

Section Services

Respondents felt the following Section services were important:

SERVICES	NO. OF RESPONDENTS
CSM & Annual Conference	44
Special Workshops & Conferences	51
JOSPT	60
OP	40
Government Relations	49
Financial support for research	58
Board Certification	56
Promote academic/clinical education	62
Regional study groups	35
Section's 800 toll-free number	44

Public Relations

Fifty-one felt that ready-made advertising of orthopaedic physical therapy would be helpful. The majority of those polled felt that a speakers kit containing 35mm color slides and a script, brochures, and television and radio service announcements would be most helpful.

Conferences and Meetings

Respondents have been practicing orthopaedic physical therapy from two to 23 years, with an average of 12 years. In the past five years, attendance at Orthopaedic Section sponsored programs have ranged from zero to nine, with an average of two programs attended. The primary reason given for not attending a Section C.E. program were: cost of transportation and hotel; time away from home, family and office; and, not interested in speakers or the content of the program.

General Information

Section membership: 2 (one year or less); 21 (2-5 yrs.); 31 (6-10 yrs.); and 20 (more than 10 yrs.).

Only six of the 74 respondents had ever served the Section in an elected or appointed position. Eleven respondents indicate an interest in serving the Section in their area of interest. Of those responding, 41 were board certified in Orthopaedics and one board certified in Sports. Eleven out of twenty stating they had attended the Review for Advanced Orthopaedic Competencies and felt it was valuable or useful. Seventy-three indicated they would likely continue their Orthopaedic Section membership next year. Fifty-six felt that the Section meets most of their expectancies; whereas, 17 felt the Section met some of their needs.

Fifty-six felt the Section leadership focused on issues of interest to the membership and seven had no opinion. Thirty-six felt the Section Board of Directors were responsive to their needs, and 26 had no opinion. Thirty-three felt the Administrative Director was responsive to their needs and 33 had no opinion. Thirty-five felt Section officers were responsive to their needs, but 28 had no opinion. Forty-two felt the Section allocates its resources wisely and 16 had no opinion. Forty-two felt the Section committees were beneficial and effective and 19 had no opinion. Fifty-one felt they had adequate opportunity to find out about and become involved in Section activities.

Summary of Respondents Perceived Needs and Goals of the Section

The respondents provided informative and sometimes detailed information on a wide variety of topics which cannot be easily summarized. The information provided will help guide the Section leadership in making decisions about Section activities and strategic planning.

Members did indicate some common opinions of Section activities in the following areas: greater involvement in government affairs; greater support for research that will justify the practice of orthopaedic physical therapy; develop-

VICE PRESIDENT cont'd

ment of preceptorships or mentorships in the specialization of orthopaedic physical therapy; continued support in specialization; and preparation for board specialty examination; support of special interest groups; and support of Section sponsored continuing education.

Thanks again to those that responded to this detailed survey.

Duane Williams, P.T., M.A.
Vice President

TREASURER

The Orthopaedic Section Executive Committee approved the 1991 Budget at the Combined Sections Meeting in Orlando, Florida. The goal of the Finance Committee was to develop an understandable budget which establishes a secure fiscal foundation for the Orthopaedic Section. Below is a summary of the 1991 budget which explains how the fiscal goal will be achieved through the implementation of the specific fiscal objectives.

IMPLEMENTING AN INVESTMENT RESERVE FUND

In previous budgets, the section has had general savings and investment account(s). From time to time depending on the expenses of the section, funds were added to or depleted from the account(s). As our section expenses continued to grow during the past years less funds were able to be deferred into the savings or investment accounts. As of December 31, 1990 less than 8% of our total expense budget was in our savings and investment accounts. The APTA suggests that sections should have a goal of at least 50% of any years expense budget earmarked in a reserve fund. Reserve funds are not used unless there are unanticipated financial difficulties such as legal liability suits, emergencies or situations which the executive committee feel are in the best fiscal interests of the section. Ideally, the section should have 100% of its annual expense budget secure in a reserve fund. The 1991 budget provides for assuring that the reserve fund grows from the current 8% to around 18% by the end of the 1991 budget year. To achieve a long range goal of having a reserve fund at 40% to 50% of our annual expenditures budget will take years to achieve; the finance committee believes, however, this annual commitment is in the best interest of the section to assure fiscal stability.

IMPLEMENTING A CAPITAL RESERVE FUND

According to the comparative balance sheet of 12/31/91 the section has $72,058 in equipment, furniture and fixtures. Previous budgets just took money from the savings accounts if equipment needed to be replaced. As our equipment assets continue to grow so does the need to provide a replacement plan that takes advantage of equipment depreciation and unexpected replacement. The capital reserve fund will assure that section equipment can be replaced without affecting the general operational budget or investment reserve fund. The finance committee has allocated $33,000 into the fund for 1991. Once the fund is in place it is anticipated that annual funding will only need to replace the capital fund to 50% of the sections gross equipment assets.

SEPARATING JOSPT INCOME AND EXPENSES

Previous section budgets have fully incorporated *The Journal of Orthopaedic and Sports Physical Therapy* operations within the Orthopaedic Section budget. Often is was difficult to quickly assess the costs of the operations for Sports and Orthopaedic section members. After consultation with section accountants, and tax attorneys, the finance committee proposed a new accounting process for *JOSPT.*

The Orthopaedic section will maintain and administer a separate account which will delineate the exact income and expenses attributable to the operation of the *JOSPT.* The 1991 budget projects it will cost the orthopaedic section $113,750 to provide the journal to the membership. That is approximately $11.38 per orthopaedic section member.

SECTION STANDING COMMITTEES

The finance committee looked closely at the actual expenses incurred by each committee as it related to the 1989 and 1990 strategic plans. Based on the performance and attainment of the past strategic plan goals, and future strategic objectives set forth by each committee the finance committee made its recommendations to the executive committee. The recommendations were reviewed and modified to best reflect the 1991 committee needs while preserving the reserve fund objectives.

EXECUTIVE COMMITTEE DISCRETIONARY PROGRAM

Often during the fiscal year various unexpected items arise that were not budgeted. In the past these expenses were assigned to a program and funded from excess income in the program, unused budgeted funds or possibly taken out of the savings accounts. By establishing a discretionary program the executive committee can fund the unexpected and not have it impact on the budgeted programs. In this way the executive committee can look at the discretionary program and make recommendations as to whether the new expenses should be put into a future strategic plan annually or if it was a one time expense. The 1991 budget provides for the executive committee to have $22,873 to fund the unexpected without impacting on the newly established reserve funds.

The 1991 budget as proposed and approved sets in place a long range goal of fiscal section stability while maintaining close accountability by all to assure that we arrive there as quickly as fiscally possible.

Bob Burles, Member
Dorothy Santi, Member
Jeff Taeger, Member
John Wadsworth, Treasurer & Chair,
Finance Committee

SHORT TERM COURSES

RATES

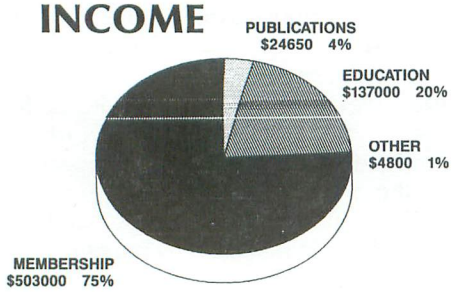
INSTRUCTIONS FOR SHORT-TERM COURSE ADVERTISEMENTS

Advertisers are requested to include all necessary information for prospective course participants. The *Orthopaedic Physical Therapy Practice* is published 4 times per year-January, May, August, November. Ad deadlines are the first day of the preceding month. Rates are $5.00 per line. Lines may be estimated on a 45 character per line basis (this includes letters, punctuation marks and spaces). The right to reject an ad or change wording is retained by the editor. Ads must be accompanied with payment. Send copy to: Orthopaedic Physical Therapy Practice, 505 King Street, Suite 103, La Crosse, WI 54601.

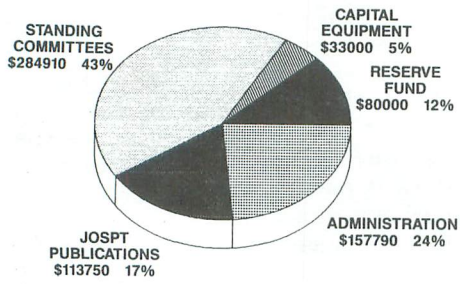
GAIT SEMINAR, September 27-28, 1991, Multi-faculty featuring Jacqueline Perry, MD, Framingham, MA. For more information: Education Resources, Inc. 16 Park St., Suite 2, Medfield, MA 02052. (508) 359-6533 or (800) 487-6530 (outside Mass.)

Orthopaedic Section 1991 Budget

INCOME



EXPENSE



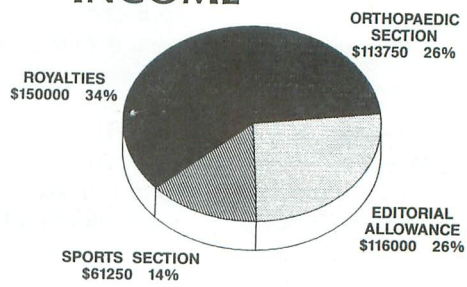
$669,450

JOSPT PUBLICATION

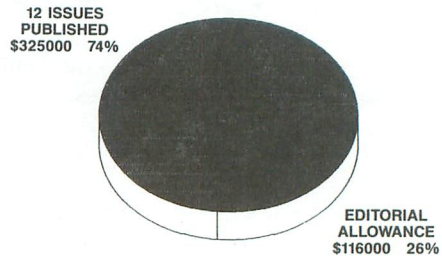
The Journal of Orthopaedic and Sports Physical Therapy

1991 Budget

INCOME



EXPENSE



$669,450

Orthopaedic Section 1991 Budget by Program

Program	Code	Income	Expenses
Governance	0001	$ 0	$ 36,920
Administration	0003	2,400	157,790
Membership Services	0004	503,000	28,005
Education Program	0005	137,000	88,584
Publications	0006	24,650	50,795
Research	0007	0	3,513
Specialization (OSC)	0008	0	23,125
Finance	0009	0	13,460
Practice Affairs	0010	0	3,330
Public Relations	0013	2,400	4,035
Awards	0014	0	3,090
JOSPT	0015	0	113,750
Nominating Committee	0016	0	7,180
Miscellaneous	0099	0	22,873
TOTAL		**$669,450**	**$556,450**
Capital Equipment		0	33,000
Reserve Fund		0	80,000
TOTAL		**$669,450**	**$669,450**
JOSPT	1015	$441,000	$441,000

ORTHOPAEDIC RESIDENCY PROGRAM DIRECTORY (including Manual Therapy)

The Section is interested in providing its members with a directory of Orthopaedic Residency Programs. To enable us to do this, we need the assistance of our members. Please contact the Section office if you can supply any information as to where such a program has been established.

1-800-444-3982

To The Membership

Please make note that the Section office has recently changed long distance companies and our new 800 number is 1-800-444-3982

EDUCATION

Several multi-section programs were conducted this year beginning with documentation on Thursday, January 31st. On Friday the Sports and Research Sections conducted programming on soft tissue injury, healing and therapy. Saturday's program included new wave in electrotherapy for physical therapy assistants. One hour of this program was specifically designed for physical therapy assistants on electrotherapy modalities.

In addition to our Industrial Physical Therapy and Foot and Ankle Roundtables, we added Manual Therapy and Head and Neck Therapy. All the roundtables were well attended. At Annual Conference we are planning meeting times in addition to our Section business meeting as follows; a one hour open forum for the roundtables on head and neck physical therapy and manual therapy, and a one hour business meeting for the Industrial Physical Therapy Special Interest Group.

The Section business meeting was moved from its traditional time on Sunday to Saturday. This proved to be of benefit since attendance significantly increased. At this meeting the Rose Excellence in Research Award was presented to Jack DiVeta, author, and Martha Walker and Bernard Skibinski, co-authors, for their article titled,"Relationship Between Performance of Selected Scapular Muscles and Scapular Abduction in Standing Subjects", Phys Ther 70:470-476, 1990. The Industrial Physical Therapy roundtable group brought forth a motion that they be recognized as special interest group of the Section. The motion was passed. We are all very excited to have them as our first special interest group. There was also much discussion on the draft Position Statement on Manipulation. A motion was made to accept this statement with approved amendments. The motion passed and the statement is published in full in this issue of *Orthopaedic Practice*.

The grand finale of 1991 CSM was the Ice Cream Extravaganza sponsored by the Research and Orthopaedic Sections Saturday, February 3rd. The ice cream was donated by Ben & Jerry's and music was supplied by a local DJ. Close to $4,000 was taken in from this event. The profit will be formally donated to The Foundation at Annual Conference.

We are pleased to announce Kent Timm, P.T., Ph.D., A.T.C., OCS, SCS, as the Editor for our Home Study Course on the Lower Extremity. This six month course is planned to begin in the Fall of 1991. Please watch for information on authors, topics and registration in upcoming issues in *JOSPT* and *OP*.

This year's "Review for Advanced Orthopaedic Competencies" course will be held at the Town & Country Hotel in San Diego, July 21-27. A Section business meeting is scheduled on July 26 to coincide with the two day program on the low back and hip. We are expecting an excellent turnout. To register for the course or obtain additional information, please contact either Terri Pericak or Sandy LaValley at the Section office.

The cooperative Canadian and American Orthopaedic Physical Therapist upcoming joint meetings will be at Annual Conference in Toronto, 1994, and in Florida in 1996.

In 1992 the Section is investigating putting on an annual orthopaedic education and business meeting in addition to activities at the Combined Sections Meeting and Annual Conference. More information will be published in the upcoming issues of *JOSPT* and *OP*.

Planning for CSM 1992 is well underway and early preliminary scheduling will be announced at Annual Conference and published in the next issue of *OP*.

Mark your calendars for the following events at Annual Conference in Boston:

Saturday, June 22
8:00-10:00 Industrial Physical Therapy Business Meeting
10:00-11:00 Head and Neck Roundtable
11:00-12:00 Manual Therapy Roundtable

Sunday, June 23
8:00-10:00 Business Meeting

See you in Boston!

Z. Annette Iglarsh, P.T., Ph.D.
Chair, Education Program Committee

PRACTICE AFFAIRS

POSITION STATEMENT ON MANIPULATION

The Orthopaedic Section, APTA recognizes that manipulative techniques by licensed physical therapists in evaluation and treatment of individuals with musculoskeletal dysfunctions has always been an integral component of physical therapy practice.

The following guidelines are further offered:

1. Manipulation in all of its forms is within the scope of practice of the licensed physical therapist.
2. The force, amplitude, direction, duration and frequency of manipulative treatment movements is discretionary decision made by the physical therapist on the basis of education and clinical experience and on the patient's clinical profile.
3. Manipulations implies a variety of manual techniques which is not exclusive to any specific profession.

SUPPLEMENTARY INFORMATION

Manipulation in its general sense means any manual procedure. The term "manipulation" comes from the Latin "manipulare" meaning to handle. Various medical and physical therapy practitioners use manipulative treatments and have many different terminologies to describe these techniques. (Refer to Glossary)

In recent years manipulation has come under greater scrutiny due to its widespread use, mostly in the treatment of back pain. Research efforts have increased in an attempt to verify the effectiveness of manipulation and to investigate its mechanism of action. The effectiveness of manipulation has been established in the short term, however, long term effectiveness has yet to be determined due to the self-limiting nature of many of the musculoskeletal problems for which it is used.[1] Attempts to explain the mechanism of action manipulation have been confounded by the general disagreement about the etiology of musculoskeletal pain. The indications for manipulative treatment, that are agreed upon are clinical rather than pathological in criteria and include: 1) asymmetry of position 2) altered range of motion 3) tissue texture abnormalities. Further confirmation as to whether manipulation is suitable depends on the patient response to treatment, making careful clinical assessment an essential element of the therapeutic process.[2]

The forementioned information is extremely important in making a decision as to which practitioners are qualified to perform manipulation. The clinical criteria for which manipulation is indicated are well within the scope of practice for the physical therapist. Provided adequate clinical experience in a disciplined environment, the physical therapist is well suited to examine the neuromusculoskeletal system, provide manual treatment as indicated and assess the response to treatment.

REFERENCES

1. Hoehler, FK, Tobis JS and Buerger AA: Spinal Manipulation for low back pain. JAMA, 245:18, 1835-38, 1981
2. Haldeman S: Spinal Manipulative Therapy: A Status Report: Clinical Orthopaedics and Related Research, 179, 62-70, Oct. 1983.

PRACTICE AFFAIRS cont'd

GLOSSARY

*Mennell infers that manipulation is a manual procedure to treat joint dysfunction, which by definition, is a loss of one or more movements of an involuntary nature which can occur at any synovial joint.

Mennell, John M., M.D.
Back Pain, pg. 29
Little, Brown and Company, 1960

*Manipulation: An accurately localized, single, quick and decisive movement of small amplitude, following careful positioning of the patient. It is not necessarily energetic and is completed before the patient can stop it. The manipulation may be a regional or a more localized effect, depending upon the technique or position of the patient.

Grieve, Gregory P., FCSP, Dip PT
Common Vertebral Joint Problems, 2nd Ed. P. 378
Churchill Livingston, 1989

*Manipulation: Defined by the Oxford English Dictionary as "to handle, deal skillfully with, manage craftily, *the term* manipulation in the professional sense, can be held to cover any manual procedure applied passively to a relaxed body part, often for the restoration of joint range and functional relationship.

Grieve, Gregory P., FCSP, Dip TP

*Manipulation: Simply defined as a passive movement at joint with a therapeutic purpose, using the hands.

Cyriax, James, M.S.
Textbook of Orthopaedic Medicine, Vol. I
Bailliere Tindal, 6th Edition, 1975, pg. 701

*Manipulation: This term is used in two distinct ways:

1. It can be used loosely to refer to any kind of "passive movement" used in examination or treatment.
2. In a restricted definition, it is used to mean a small amplitude, rapid movement (not necessarily performed at the limit of a range of movement), which the patient cannot prevent from taking place.

*Mobilization: This is another "passive movement" but its rhythm and grade are such that the patient can prevent its being performed.

Maitland, G.D.
Vertebral Manipulation, 5th Ed.,
Butterworth, 1986

*Manipulation: Any manual procedure used for the purpose of examination, correction, or modification of an articular or soft tissue dysfunction.

*Mobilization: The act of imparting movement, either actively or passively, to a joint or soft tissue.

Terminology of Orthopaedic Physical Therapy, Orthopaedic Section, APTA

*". . . in physical therapy, the *forceful* passive movement to a point beyond its *active limits* of range."

Dorland's Medical Dictionary

*Manipulation . . . to operate or control by skilled use of hands.

The American Heritage Dictionary

*Manipulation: The skilled passive movement to a joint.

Paris, S.V.,
Physical Therapy, Vol. 49, #8,
Aug 1979

*Manipulation vs Mobilization

The term "mobilization" is identical in meaning with the word "manipulation." They are interchangeable. Mobilization has been the more common term in the United States due to physical therapists wishing to avoid the word "manipulation" which has to some an implied association with chiropractic. While that might have been true it is no longer the case. In medical journals they refer to manipulation and recognize our role in it. (*Spinal Manipulative Therapy,* Clinical Orthopaedics and Related Research, S.V. Paris, #179, Oct. 1983).

Garvice Nicholson, M.S., P.T., OCS
Chair, Practice Affairs Committee

PUBLIC RELATIONS

The Chairman and committee members, Karen Piegorsch, attended the Combined Sections Meeting in Orlando, Florida. The new Section display booth was utilized for the first time, and we received many compliments on it.

Our 1991 goals include preparing an article for *OP* about the impact of Certification/Specialization on those practicing therapists who have passed the certification exam, and working with the membership with regard to a phone/fax survey.

Jonathan Cooperman, M.S., P.T.
Chair, Public Relations Committee

The Journal of Orthopaedics and Sports Physical Therapy

Meet the New JOSPT Editorial Team at the 1991 APTA Conference

Dr. Gary L. Smidt, JOSPT editor, and Debra A. Durham, JOSPT managing editor, will be on hand to hear suggestions and answer questions regarding *The Journal of Orthopaedic and Sports Physical Therapy* at the 1991 Annual APTA Conference in Boston.

The new editorial team will be available in the booths of the Orthopaedic and Sports Physical Therapy sections at various times throughout the conference. Feel free to stop by and introduce yourself to the new staff. We welcome the opportunity to chat with you!

Gary Smidt, P.T., Ph.D., FAPTA
Editor

NOMINATIONS

Ballots will be soon arriving in your mailbox for the candidates slated at CSM for the positions of Member-at-Large and Nominating Committee member. The following is a list of the candidates:

Nominating Committee Member:
Courtney Bryan, PT
Gregg Smith, EdD, PT
Susan Stralka, PT

Member-at-Large:
Nancy Byl, PhD, PT
Michael Cibulka, MS, PT
Stanley Paris, PhD, PT

Please watch for the upcoming ballot and remember to VOTE!

Scott Hasson, Ed.D., P.T.
Chair, Nominating Committee

Industrial Physical Therapy Special Interest Group of the Orthopaedic Section

The special interest group formation meeting was held at 2:30 p.m., January 31, 1991 at the Combined Section Meeting in Orlando, Florida. It was preceded by a presentation on pre-work screening by a joint program of the Private Practice Section and Orthopaedic Section. The speaker was Oscar Spurlin, Ph.D., a pyschologist who has developed national pre-work screening programs.

Forty physical therapists were in attendance at this meeting.

There was a review of last year's round table program and discussions on the formation of a special interest group (SIG) for physical therapists involved in industrial physical therapy practice. The Orthopaedic Executive Committee "proposed Guidelines for Special Interest Groups" were made available by handout to the group. The Orthopaedic Section has now made it possible for this formation to be created.

There was a short discussion regarding the feasibility of starting an independent section as compared to becoming a Special Interest Group under the Orthopaedic Section. While a section was given strong consideration, at this time there would be a two year lapse before all of the proper procedures could be finalized for this formation. By unanimous decision the group of 40 therapists present voted to petition the Orthopaedic Section for acceptance as a formal Special Interest Group.

There was a brief discussion on the need for an appropriate title for the group but this question was deferred to a later meeting.

Regarding the positions of chairperson and committees of the new SIG, it was recommended by Jan Richardson, President of the Orthopaedic Section, that the SIG have an interim officer and committees until the proper nomination and appointing process could be developed. The target date for formal elections and appointment of committees will be the Combined Sections Meeting 1992.

The interim (one year) chair was elected from the group. Susan Isernhagen will serve as acting chair through this organization year and until a chairman can be formally elected in 1992. At that time, the chairperson's term will be three years as stated in the Orthopaedic Section guidelines.

Three acting committees were also formed. Volunteers were taken from the group present for those committees. Bob King is acting chair of the Program Committee. He and his group will develop a program for the Combined Sections Meeting 1992. Glenda Key is acting chair of the Nominating Committee. She and her committee will review proper procedures for the Nominating Committee and ask for a slate of candidates for the chairperson election in 1992. Roberta Kaiser and Susan Godsen will serve as temporary Bylaws Committee and review the need for the SIG's bylaws to be presented to the group in 1992.

The next brief meeting will be at APTA National Conference in Boston in June. A short time will be set aside for a meeting which will be a report of the temporary chairman and committees as to the progress of the organizational status. If time permits, a short program will also be given.

The next major meeting of the group will be a Combined Section meeting in 1992. The Orthopaedic Section will allow special programming for this group. There will also be a business meeting with election of officers and formal appointment of committees.

Also, given during this organizational meeting were three reports.

1. Bob Richardson reported on the APTA committee formed to discuss definitions of "Work Hardening" and "Work Conditioning" and present them to the Board of Directors in the March meeting. A committee of five; Bob Richardson, Peter Towne, Rick Shutes, Jan Richardson, and Susan Isernhagen discussed the formation of APTA definitions and react to CARF's definition of Work Hardening. Also present in Washington, D.C. for this January meeting was Jackie Montgomery, APTA's CARF representative. Definitions were developed with guidelines for both Work Conditioning and Work Hardening. This will be presented to the APTA Board of Directors in March. If the Board approves these definitions for study, the papers developed by the committee will then be disseminated to interested physical therapists for a review process. It is at that time that a Special Interest Group roster will be helpful in review of these definitions and guidelines.

2. Jill Floberg reported on her questionnaire of pre-work screening. She submitted a questionnaire to the Private Practice Section on the Orthopaedic Section for response on physical therapists' current involvement in pre-work screening. There was a response of 31 people. Excerpts were given as handouts at the meeting. Jill pointed out that while many therapists are currently using screening, there have not been physical therapy validation studies of this same screening. This is a need for the future.

3. Susan Isernhagen reported on the work hardening/work conditioning questionnaire disseminated to the Orthopaedic Section through the quarterly publication. There were 39 respondents. Eighteen of the 39 practices used only physical therapy in their program. The others added a variety of occupational therapy, psychology, vocational counseling and physician usage. The average program was four hours per day with an average five days per week. The average work rehabilitation program took five weeks. Approximately half of the group did quality assurance programs regarding outcome. While it is not known what type of studies were done, the average return to work statistics given by the group was 73 percent of clients returned to work.

The diversity of the responses would indicate that physical therapists are practicing anywhere from physical restoration programs to work conditioning programs, to CARF accredited work hardening programs. This brings up the need for better definition and discussion by a Special Interest Group to help define and explain our practice.

Those therapists interested in participating in this special interest group can do so by participating in the brief meeting scheduled at Annual Conference in Boston and a larger meeting to be held at the Combined Sections Meeting in 1992. Any further questions can be directed to:

Susan Isernhagen, P.T.
2202 Water Street
Duluth, MN 55812
(218) 728-6455

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Lightweight, adjusts easily for fitting, easy to don and doff and with complete instructions.

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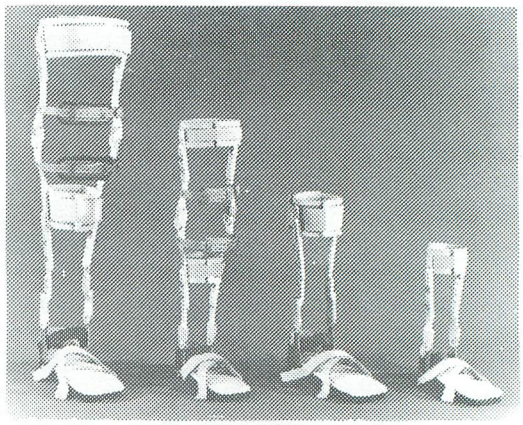
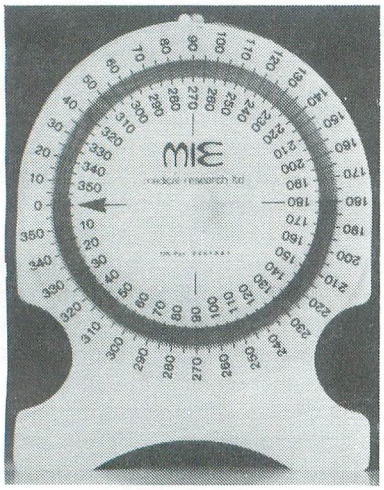
- Inexpensive



BK-AK Interchangeable Training Orthoses
Worn on either leg, adjustable, anterior and posterior openings on all cuffs, sets up for plantarflexion, dorsiflexion or solid stop at ankle.

The A-F™ Orthosis
8 oz. weight, one size for right or left foot, no drilling of shoes, no mounting of stirrup or removing of heel, can be attached to any shoe with normal heel and sole wedge, transferrable from shoe to shoe.

- Provides dorsiflexion assist



M.I.E. Clinical Inclinometer
— To measure range of motion on the body.

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• OTHER UNIQUE PRODUCTS
• WEIGHT BEARING INDICATORS
— To assist the therapist in post-op patient handling.
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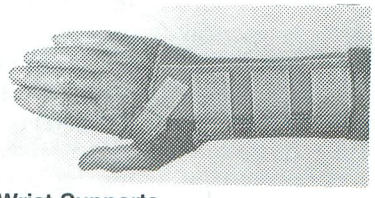

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- **Allows for LUMBAR MOBILITY while providing PELVIC STABILITY.**

The "S-I" Support utilizes an anatomically compatible padding and tightening system that creates an **extension** force on the sacrum and a **compressive** force on the soft tissues and joint surfaces of the sacroiliac region. These combined forces from the back, coupled with the posterior iliac rotation force from the front converge to create **SACROILIAC STABILIZATION.**

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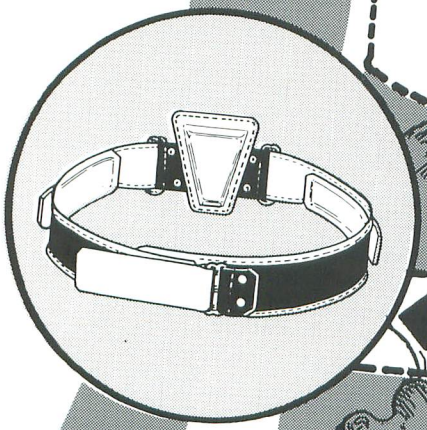
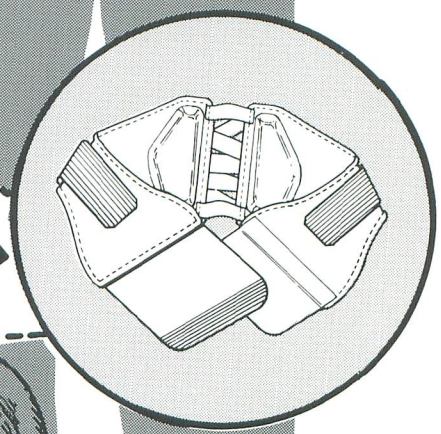
THE LUMBAR STABILIZER

- **Compresses and/or stabilizes the Lumbar Spine by utilizing an anatomically capatible padding and tightening system**

The first line management in any acute musculoskeletal syndrome is rest or **restriction** from destructive activity. **Protection** of injured tissues by minimizing and reducing forces is imperative for the initiation of proper healing.

Supporting injured tissues during progressive movement retraining programs (rehabilitation) is essential for successful low back management.





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The purpose of the "Review for Advanced Orthopaedic Competencies" is to provide Orthopaedic Section members and non-members with a process for review. (It is not intended to satisfy examination criteria for the Orthopaedic Physical Therapy Specialty Competency examination, but to serve as a **review process only.)**

See page 2 for registration and hotel information.