ORTHOPAEDIC PHYSICAL THERAPY PRACTICE

THE NEWSLETTER OF
THE ORTHOPAEDIC SECTION
AMERICAN PHYSICAL THERAPY ASSOCIATION

VOL. 10, No. 2 SPRING 1998

Orthopaedic Physical Therapy Home Study Course

Pharmacology 98-2

July - December 1998

Proposed Topics and Authors

Introduction to Pharmacology
Lynne J. Eddy, PhD, PT

Musculoskeletal Medications
Louis C. Almekinders, MD

Endocrine Medications
Elaine Betts, PhD, PT

Neurologic Medications
Clyde B. Killian, PhD, PT & Milo N. Lipovac, MD

Cardiopulmonary Medications - Implications for PT Management
Claire Peel, PhD, PT

Pediatric Medications
Barbara Connolly, EdD, PT

Registration Fees

Register by June 1, 1998.
Limited supply available after this date.

$150 Orthopaedic Section Members

$225 APTA Members

$300 Non-APTA Members

Special discounted rates are available for institutions with multiple registrants. Please call the section office for complete information.

*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.

Educational Credit

30 contact hours

A certificate of completion will be awarded to participants after successfully completing the final test. Only the registrant named will obtain the CEUs. No exceptions will be made. ATC approved.

Objective: The objective of the Orthopaedic Section Home Study Course is to provide a self-paced learning experience on classification and application of pharmacologic agents to various types of patients.

Editor
Carolyn Wadsworth, MS, PT, CHT, OCS

Subject Matter Expert
Michael Moran, ScD, PT

Additional Questions

Orthopaedic Section, APTA, 1-800-444-3982 x 213

8-2 Home Study Registration Form

Name _____

For clarity, enclose a business card.

Mailing Address _____

City _____ State _____ Zip _____

Daytime Telephone No.(_____) _____ APTA# _____

Please make check payable to: Orthopaedic Section, APTA

Please check:
- ☐ Orthopaedic Section Member
- ☐ APTA Member
- ☐ Non-APTA Member

(Wisconsin Residents add 5.5% Sales Tax)

☐ I wish to become an Orthopaedic Section Member ($50) and take advantage of the member rate.

Fax registration & Visa or MasterCard number to: 608-788-3965

Visa/MC (circle one)# _____ Exp. _____

Signature _____

Mail Check and registration to: Orthopaedic Section, APTA, 2920 East Avenue South, Ste. 200, La Crosse, WI 54601

ORTHOPAEDIC PHYSICAL THERAPY PRACTICE

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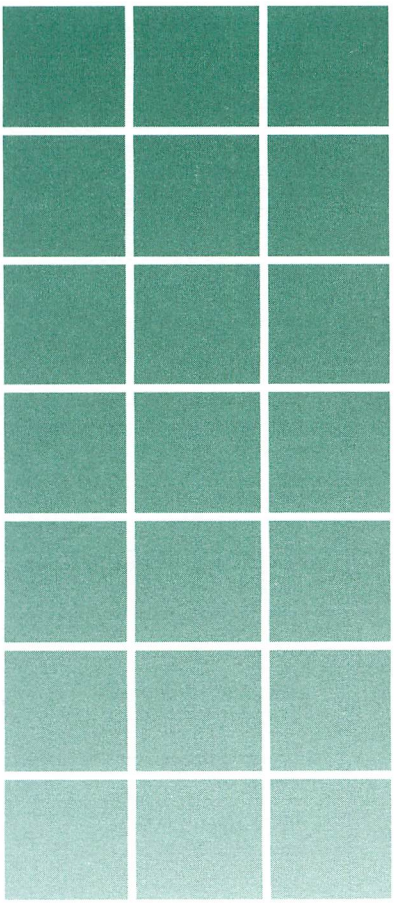

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REGULAR FEATURES

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"One More Time"

Spring - a time of rebirth and for me a time to annually renew my energies. And so it is for this issue of *OP* whose rebirth of sorts comes with a new editor. **Susan Appling** has been appointed by the Board, and I welcome her on behalf of the Section. I wish her all the best, knowing that she is blessed with a phenomenal support group headed by Sharon Klinski, the managing editor. I have arranged to keep in close touch with Sharon by phone, fax, and e-mail, for fear that *OP* withdrawal will set in.

Even though Susan now officially holds the reins, I have been given the honor of writing one last piece - to throw my last two cents down on paper. And so it goes. Six years and more than 25 issues later, I still sit at the computer and wait for inspiration. I sit and wonder why I can't recall, on demand, all of those wonderful editorials, written in my mind's eye at 5:45 AM while driving to work. Aided by that first cup of caffeine surging through my system like some illicit drug, I have written the most insightful editorials. But they are buried somewhere in my brain beneath a mound of disorganized trivia that takes up room necessary for important information - data for which no tickler file is forthcoming. I still sit and wonder where all those scraps of paper are - the ones with the scribbled ideas and plans which, if ever implemented, would shape the future of physical therapy. I sit and I'm amazed at the thought that some members have actually read past editorials, and I wonder why?

I suppose I could answer my own questions. Unless committed to paper, words and ideas are as fleeting as a snowflake landing on a sun-warmed piece of metal. And it's probably delusional to think that I could solve any of our profession's problems, but at least I've given them serious thought. As for others reading what I've written - I have no ready answer for that. I do know that I've stirred the pot more than once. That too, is a transient thing. The hot-button issues of just a few short years ago, are no longer on the tips of everyone's tongues. It wasn't so very long ago that I wrote a scathing indictment of referral for profit. Does anyone put that on top of their list of concerns anymore? Sometimes these changes seem to pass by like some political stealth bomber - we don't even realize the issues are gone. Health care in general and physical therapy in particular, are rapidly changing. For example, even though the clinical diagnoses I encounter have changed very little throughout my career, patients, on the other hand, have changed a lot. They are much more demanding than ever before. Part of that is because we have a more informed consumer, and that's a good thing! But there is also a growing number of patients that still demand the quick fix, or worse, seem to want no fix at all because of some secondary gain. The American dream of hard work with its long-term payoff for the individual and his or her children has turned into the "get it now, and get it easy" mentality. Too many patients think that the support systems in place are hammocks, rather than safety nets, or that they should bring suit and hope for a big payday. This "win-the-lottery" thought process has hardened my edges, and made me a strong patient advocate in too few, select cases. Managed care has changed the way we approach clinical problems and tightened more than a few belts. The Balanced Budget Act of 1997 will surely affect us all.

But easy as it might be, I don't want to go out on a cynical note. Despite the problems that face our profession, it's still great to be a physical therapist. The Section is stronger than ever before, and we have tremendous financial resources that help to carry out our mission of promoting practice, education, and research in orthopaedic physical therapy. The Section leadership is committed to you - its members. However, the membership is not heard from often enough. The vocal and politically astute few, with their own agendas, will recreate the Section in their own image unless the average member is heard from. I implore those of you that care enough to pay dues to take a more active role in the Section. Vote in Section elections (we seldom exceed 12% return on ballots); run for office; e-mail, fax or call the officers; write letters to the editor; provide responses to commentaries in OP; volunteer to serve on committees; answer surveys that are mailed to you; attend roundtables and forums at CSM; submit articles to OP. In short...get involved!

I've had a great ride! Being Editor of this publication has afforded me a fantastic opportunity to learn, to get to know wonderful people, and to serve. I thank you all.

Jonathan M. Cooperman, JD, MS, PT
Outgoing Editor, *OP*

Editor's Note

Rebirth and Renewal

As Jonathan Cooperman noted in his editorial, Spring is a time of rebirth. Change is abundant everywhere you look—in the trees, the temperature, the sunshine, and even the *OP* editor. While many changes go unnoticed because they are small or occur gradually, others are large and do not occur without some pain and discourse. Change, as it occurs in Spring, can be a wonderful time of growth and renewal resulting in a beautiful "flowering" of the object of change. Change can also be, as in adolescence, a particularly challenging time that is not without angst. Whether it be with beauty or angst, change is now on the horizon for the Association as well.

In 1997, the APTA House of Delegates passed RC 40. With this act, the Board of Directors was charged to develop proposed changes to APTA's governance and organizational structure. Those proposed changes have resulted in the development of RC 1-98 APTA Bylaws Revision, which is scheduled to be the first order of business in the 1998 House. In the January 1998 issue of *PT Magazine*, APTA President Jan K. Richardson, PhD, PT, OCS discusses the proposed changes in organizational structure of the Association in her article "RC-40: Affiliate Members' Chance to Grow." In addition, she briefly describes the method by which the proposal was formulated. The Affiliate Assembly has been engaged in dialogue with the Board and now has cosponsored RC 1-98. President Richardson describes the proposed bylaws revision as "a bold step...offering a vision for our future."

RC 1-98 proposes the formation of the *American College of Physical Therapists* and the *National Assembly of Physical Therapist Assistants*. The composition of the House of Delegates changes with this proposal. Affiliate representation is most markedly changed, primarily by removing 1) voting privilege in the House, and 2) affiliate representation in the Chapter delegation. As with all nonvoting delegates, those of the National Assembly will retain the right to speak and make motions. The House will remain the policy-making body of the College. The plan suggests formation of a parallel representative body of the National Assembly. RC 1-98 will surely bring to the floor of the House a great array of discussion regarding the role of the PTA within the Association. This, however, will not be a new occurrence.

Many of you may remember previous discussions in the House regarding the role of the PTA—both in practice and in governance. Historically, this issue has been hotly debated for years and has been a source of pain and strife for those on both sides of the proverbial fence. Controversy and differences of opinion remain.

In this issue of *OP*, Melinda L. Merrigan, MEd, PTA, has given us her view of the role of the PTA in orthopaedics, as well as the opinions of other PTAs and PTs. Douglas White, PT, OCS has written a "Letter to the Editor" in response to a previously published article by Alicia Dittmar, MEd, PT, entitled, "Clinical Problem Solving and Physical Therapist Assistants." I hope you will find these commentaries thought-provoking. You may even become inflamed. Many of you may feel passionately about the role of the PTA and the proposed reorganization of the Association. Anything you become passionate about is worthy of your attention.

Rebirth and Renewal are the order of the day. Will we face the challenge with determination and achieve a mutually beneficial solution? Or, will we dig in our heels and remain undecided and divided on this issue? The choice is ours to make. The challenge belongs to each of us, not just to those members who will serve as delegates to the 1998 House. Read the proposed bylaws revision in the April issue of *PT Magazine*. Talk with your elected delegates and express your opinion. Put this issue on the agenda at your Spring Chapter meeting. Attend sessions of the House of Delegates in Orlando. In short, renew your commitment to your Association.

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

President's Message

CSM 1998

The thousands of physical therapists and physical therapist assistants who invaded Boston this past February were treated to outstanding educational programming, lively business meetings, dozens of research poster presentations, and an immense exhibit hall. Complaints of wanting to be in more than one place at one time were frequently heard. There may be a legitimate place for human cloning after all!

We had a tremendous turnout for our Annual Business Meeting. A significant portion of the discussion revolved around the proposed Section strategic plan that was printed in the last issue of this newsletter. The valuable input from membership will allow the Section Board of Directors to finalize the document at the June 1998 SME to be held in Orlando. The strategic plan will then be reviewed annually.

Outgoing Committee Chairs

This CSM marked the end of a number of committee chair terms: Catherine Patla (Nominating Committee), Mari Bosworth (PR Committee), Joe Godges (Orthopaedic Specialty Council), Dan Riddle (Research Committee), and Jonathan Cooperman (Editor: *OP*). We are indebted to these individuals for their dedicated service to the Section. Dan Riddle and Jonathan Cooperman deserve special mention. Dan served as Chair of the Research Committee for eight years. The Section's research agenda was essentially set during Dan's tenure and the tremendous growth of Section research activity is testimony to his influence. Jonathan completed his sixth year as editor of *OP*. His continued striving for a newsletter that was reader friendly, informative, provocative, and educational led to significant growth of *OP*.

JOSPT UPDATE

1998 will be known as the year of transition when the history of the Journal is chronicled. We will be transitioning from one publishing company to another, one Editor-in-Chief to another, and moving the Journal office from one location to another. In May 1997 the Orthopaedic and Sports Sections' executive committees narrowed the field of potential Journal publishers to two; Williams and Wilkins (current publisher) and Allen Press Inc. After extensive negotiations, Allen Press Inc. was selected. Even though our contract with Williams and Wilkins extends to December 31, 1998 the transitioning of publishing responsibilities will begin in July 1998. Allen Press Inc., located in Lawrence, Kansas, has been in the publishing business for over 40 years and they currently publish over 300 journal titles. The financial terms of the contract will allow the Sections to provide the resources necessary for the continued growth of *JOSPT*. We are looking forward to formally becoming partners with Allen Press.

During CSM, the Editor-in-Chief Search Committee (Dan Riddle, Nancy White, Dorothy Santi, George Davies, and Mark DeCarlo) interviewed the five editor candidates. A final selection will be made shortly after CSM. Even though Dr. Smidt's (current editor-in-chief) contract extends to December 31, 1998, the new editor will begin his/her duties in July 1998. Lastly, the new Journal office (housed in the Orthopaedic Section Professional Building) will open in July 1998. A detailed plan for the gradual transition of manuscript reviewing and editing responsibilities has been formulated.

The executive committees of the Orthopaedic and Sports Sections are cognizant of what an important member benefit *JOSPT* is. We are investing significant amounts of time and resources to assist in the decision-making process related to the described changes. In addition, the Sections hired an external consultant to advise and assist us with the important issues. We are confident that the 1998 transitions will occur smoothly, allowing *JOSPT* to continue to flourish and evolve.

Clinical Residencies - A job well done or a job just begun?

I am very pleased to announce that at their November 1997 meeting the American Physical Therapy Association (APTA) Board of Directors (BOD) agreed to implement a postprofessional clinical residency program credentialing process, beginning January 1, 1998. To oversee the process a five member committee on clinical residency credentialing has been appointed. After soliciting recommendations from the Components, the APTA BOD selected Mike Cibulka, Jay Irrgang, Joe Godges, Colleen Kigin, and Toby Long to serve on this vital committee. The credentialing guidelines provide requirements for those interested in developing a postprofessional clinical residency program. The guidelines do NOT dictate the content of the residencies. For orthopaedic residencies, The Description of Advanced Clinical Practice, developed by members of the Orthopaedic Specialty Council, will provide the directives for specific content. To facilitate the application process for those interested in developing a residency program, the Committee on Clinical Residency Credentialing will create a residency program manual that will include sample documents, forms, and procedures. The Orthopaedic Section Board of Directors has also earmarked money for the formulation of a task force in 1998 to develop self-help materials for prospective orthopaedic clinical residencies.

The welcomed APTA BOD November decision marks the cumulative efforts of literally hundreds of committed physical therapists. For example, approximately 400 physical therapists attended a clinical residency open forum held in Reno, Nevada during Combined Sections Meeting 1995. That same year, another 400 physical therapists completed a clinical residency survey developed by the original task force chaired by Carol Jo Tichenor. In 1997, 180 therapists reviewed the residency program credentialing guidelines proposed by the third task force. The feedback received resulted in some significant modifications in the document that ultimately went to the APTA BOD in November.

Among the hundreds of contributors, two deserve special mention: Carol Jo Tichenor, MA, PT and Jan Richardson, PT, PhD, OCS. Carol Jo chaired the original eight member task force appointed by the APTA BOD in March 1994. Starting with a blank slate, this group, under Carol Jo's leadership, laid down the foundation for the current document and process. Jan Richardson, who was a part of all three APTA clinical residency task forces, was the one constant thread linking the efforts in 1994 to those of 1997. Her persistent support for this issue was vital to the eventual successful outcome.

Does the recent APTA BOD action

mark the completion of a job well done or a job just begun? The answer is both. The fact that our national organization has agreed to oversee the credentialing process is a victory earned by many. Through the development of quality assurance standards, we have a system designed to protect the consumer-those therapists interested in pursuing formal postprofessional clinical education. This system also allows for residency sites to be evaluated by clinical education experts who will provide feedback designed to enhance the programs.

Despite the hard earned victory though the real job has just begun. The intent of the third task force and the APTA BOD is for this credentialing document to be a dynamic one. The process needs to be nurtured, tested, and challenged by a supportive constituency. Only through our participation will the process evolve appropriately. I believe it is essential that these clinical residencies be viewed as one component of a postprofessional education continuum for physical therapists and not as an isolated entity. Can they be linked to the current specialization process, to credentialed fellowships, or even to the DPT degree? I believe this type of linkage is vital if our profession is to put forth a consistent and credible postprofessional education structure that meets the future needs of our practitioners.

I congratulate the current APTA BOD for their willingness to take on the credentialing of clinical residency programs. It is now up to us to take advantage of this opportunity, an opportunity we can not afford to waste. If you would like information regarding the credentialing process, please contact the Department of Professional Development at APTA, 800-999-2782 x3206

Etc.

1. A huge thank you goes to the Section office staff, committee members, chairs, and officers for all of their hard work that contributed to a successful meeting.
2. Welcome to Susan Appling, Phil McClure, and Terry Randle - incoming *OP* Editor, Research Committee Chair, and PR Committee Chair respectively.
3. Thank you Fran Welk for resolving the white paper mystery.
4. Welcome to the Veterinary Physical Therapy SIG. Congratulations Lin McGonagle and Gwynn Oakes!
5. The Pack will be back! (I hope)

William G. Boissonnault, MS PT
President

From the Section Office

Terri A. DeFlorian, Executive Director

The Board of Directors met during the Combined Sections Meeting in Boston, Massachusetts last February. Please see the minutes from the Business Meeting and Board of Directors Meeting in this issue of *OP.*

We have included something new in this issue. It is the 1997 Annual Report of the Orthopaedic Section. This report appears at the end of *OP* and contains highlights of the Section's accomplishments in 1997. This is our first effort at putting together an annual report, and I welcome any feedback you may have. We plan on including an annual report in the spring issue of *OP* each year.

The Section is preparing for the 1998 Scientific Meeting and Exposition (SME) to be held in Orlando, Florida from June 5 - 8. Following is the Section's meeting schedule:

Section Board of Directors Meeting
Friday, June 5
8:00 - 10:30 AM and
Noon - 3:30 PM
Section Business/Practice Issues Forum
Saturday, June 6
5:30 - 6:00 PM

I am happy to say that the Section office is fully staffed once again with seven full-time employees. Please feel free to contact us with any comments, suggestions, or concerns regarding any of the member services the Section offers.

Section Members in the News

❖ ❖ ❖

Nancy T. White, MS, PT, OCS has recently been appointed to the Board of Trustees of the Foundation for Physical Therapy Research. Nancy will represent the APTA Sections on the Board of Trustees. Congratulations Nancy!

❖

G Kelly Fitzgerald, MS, PT, OCS and Daniel Riddle, MS, PT recently received ASAE's Gold Circle Award as part of a team of outside editors. *Writing Case Reports: A How-to-Manual for Clinicians* received a Certificate of Achievement in the One-Time Publications category. A step-by-step instructional guide that was one of 43 entries, *Writing Case Reports* received the only award given in that category. Congratulations to Kelly and Dan!

❖

Michael Cibulka, MS, PT, OCS and Joe Godges, MS, PT, OCS have recently been appointed to a 5-member Oversight Committee for APTA Credentialling of the Clinical Residency Programs. Congratulations to Mike and Joe!

NEW Educational Opportunities Coming This Fall!

The Orthopaedic Section, APTA, Inc. is sponsoring weekend courses this year.

FOOT & ANKLE DYSFUNCTION: A Case Study Approach

November 6-8, 1998 * National Institutes of Health, Bethesda, MD

Course Description: This workshop will provide the clinical and scientific knowledge needed to effectively evaluate and treat a variety of conditions affecting the foot and ankle. Topics included are: functional anatomy; the application of functional anatomy during dynamic movement of the foot and ankle; the utilization of footwear and foot orthoses in management programs; and evaluation and management protocols used in the treatment of foot and ankle problems associated with orthopaedic & sports injuries, diabetes, and rheumatoid arthritis. A special feature will be the use of multiple case studies to clarify the scientific and clinical information presented. Case study reviews will comprise approximately 25% of the total course contact hours. (Orthopaedic Section members: $165.00, Nonmembers: $220.00; Level: Intermediate - Advanced)

Speakers: Susan Appling, MS, PT, OCS; Joseph Shrader, PT, CPed; Michael Mueller, PhD, PT; Gary Hunt, MS, PT, OCS; Jim Birke, PhD, PT; and Thomas McPoil, PhD, PT, ATC

DEMYSTIFYING LOW BACK PAIN
INTEGRATING RESEARCH INTO CLINICAL PRACTICE

September 12 - 13, 1998 * Atlanta Airport Marriott, Atlanta, GA

Course Description: This course is designed to teach assessment and treatment of the patient with low back pain utilizing an evidence-based approach, and to critically examine assessment and treatment options for scientific basis and rationale. Participants will be able to: perform a screening process to identify serious pathology and a rational clinical examination, understand the functional anatomy related to the low back, identify treatment strategies demonstrated through outcome studies to be successful in the management of LBP, understand the use of functional assessment and outcome questionnaires, learn the possible sources of LBP, and learn to incorporate operant conditioning, quotas, activation, and education into management of the patient with LBP. (Orthopaedic Section members: $125.00, Nonmembers: $180.00; Level: Multi-level)

Speakers: Ian Barstow, PT; Mark Bishop, PT; and Jeff Gilliam, MHS, PT, OCS

EQUINE PHYSICAL THERAPY I

October 1998 (actual dates to be determined)

College of Agriculture and Life Sciences and College of Veterinary Medicine, Ithaca, NY

Course Description: Basic level course to include comparative anatomy and physiology, biomechanics of movement, assessment, identification and treatment of common musculoskeletal problems, and a tour of the Equine Performance Center. (Orthopaedic Section members: $165.00, Nonmembers: $220.00; Level: Basic/Intermediate)

Speakers: Lin McGonagle, MSPT, BS - Animal Science; Amanda Sutton, MCSP, SRP, Grad Dip Phys

Special Rates available for Physical Therapist Assistants and Students.
Contact the Orthopaedic Section office for more details!
2920 East Ave. South, La Crosse, WI 54601
800/444-3982 * 608/788-3965 (FAX)
tfred@centuryinter.net

Rose Excellence in Research Award Acceptance Speech - February 14, 1998

By Diane U. Jette, DSc, PT

Thank you for this truly wonderful honor. Alan Jette, my co-author, and I accept this honor with great pride and a small chuckle at the irony of our situation. Congratulations have come from our colleagues along with a bit of a quizzical look. They recognize and we surmise that this may be the first time this award has been given to two physical therapists who would have a bit of difficulty finding their way around examination and evaluation of a patient with an orthopaedic problem; I would be sure the patient was dyspneic and Alan would find him aged and functionally limited! Thus, this award says much about the open-mindedness of the Orthopaedic Section and the legacy of Steve Rose.

I have been asked to speak tonight about the potential impact of our work on practice. There are multiple dimensions to practice and I believe that our paper, similarly, has a multidimensional message. There are, we hope, important messages about the relationship of treatments to outcomes that are meaningful to patients. For example, our findings suggest the relationship of endurance exercise to improved outcomes in patients with either cervical or lumbar spinal impairments. We also found that patients who received heat or cold modalities had worse outcomes than those who did not. These two findings together seem to suggest the need for active interventions in improving the health of individuals with spinal impairments. In fact, we hear new evidence almost every week in the public media about the health benefits of endurance exercise...it seems to be the magic pill, or to some, unfortunately, a bitter pill!! Our greatest challenge, therefore, may be working with people so they may find and sustain the motivation to make life-style changes.

Our paper also contains hints about the wide variety of practice patterns in physical therapy. Our medical and epidemiology colleagues are ahead of us in examining practice patterns. Their research has shown that there is quite a bit to be learned about a profession through careful observation and analysis of the decisions made by practitioners. In our sample, 96% of patients had received a combination of treatments (2 or more of 7 possible interventions). This discovery lead us to further explore the question of which factors contribute to a clinician's decision to provide a patient with a particular treatment. The answers were quite interesting and can be found in the December issue of the *Archives of Physical Medicine and Rehabilitation.*

Our paper also holds messages about the benefits and problems associated with large multisite data collection efforts and research involving the use of clinically derived "outcomes" data. I would like to spend a few minutes discussing this issue, because there seems to be a rapid move toward implementing "outcomes" databases in our profession.

As all of us who are in it recognize, the world of health care today is challenging and demanding. From all sectors, there are demands for cost containment, accountability, and high levels of patient satisfaction. No matter which role we play in this world, we can expect to be held accountable for efficient, effective, scientific, and empathic care which results in excellent outcomes and satisfied patients. Recognition of this fact leads us to the question of which interventions or patterns of practice can provide the results expected by patients, insurers, employers, and clinicians, with efficiency, and at the least cost. What "results" should be measured and how should we measure them? Determining the answers to these questions is a daunting task; but I believe that publication of our paper demonstrates that the profession of physical therapy has the essential ingredients for finding answers.

One important element is the growing recognition that important information about treatment and outcomes can be derived from studies that are not of the classic experimental model. Many scientists will argue that the ability to draw inferences about cause and effect is possible only in experimental designs. However, observational designs present us with several advantages. In experimental designs, the goals of the study rather than patients' needs dictate the treatment exposure. Experiments are feasible, therefore, only in situations where subjects can be assured that no better treatment is available than that potentially provided by the protocol.[1] In addition, in most experiments, conditions are controlled to the point where "real world" influences are limited; for example, only certain interested subjects volunteer and their adherence to the protocol is tightly monitored. Cost is also a major limitation, especially if enough patients are to be enrolled to obtain sufficient statistical power. Observational studies on the other hand, are less costly and are not restricted by the ethical considerations I have mentioned; everyday occurrences produce conditions that might have been artificially contrived in the experimental setting and can be studied under natural circumstances.[1] Control can be imposed by the careful selection of the groups of patients to examine and compare and the judicious use of statistics. Additionally, it may be only through observational designs that we obtain the number of patients that is required to provide stable estimates of the relationships between treatment and health outcomes. Finally, observational studies are a fertile source for new hypotheses which can be tested experimentally. Even when experimental studies are not feasible, accumulated results

from observational studies that are consistent and provide fairly strong estimates of the relationships between treatments and outcomes, can serve as support for changing practice.

Another ingredient in the search for answers is the collaboration of the many types of practitioners of physical therapy, including clinicians, researchers, and administrators. As many of you may know, the data for this paper were obtained from the first year of data collection by the FOTO Network (Focus on Therapeutic Outcomes). Such collection of data among physical therapists, across practice settings, for use in answering multiple questions about function and disability, is relatively new in our profession. Use of large databases for examining patterns of disease and factors associated with disease are common and well known among our colleagues in epidemiology and medicine. The Framingham Study and The Nurses' Health Study are well known examples and they have provided the public with some of the most commonly accepted health imperatives. As a profession, physical therapy is learning the potential benefits of such data collection; and, I believe, we sincerely want to have the data which would allow us to be intellectual in our approach to practice. The struggle is to make it happen.

The FOTO database included incredible amounts of data about practices, therapists, patients, and treatments. It required the dedication and partnership of many: health care administrators who understood the importance of explicating practice patterns and the outcomes of practice; researchers with an expertise in systematic data collection, reporting, and analysis; and clinicians willing to learn and adopt new methods of systematically collecting data and documenting their interventions.Through this partnership model, data were collected on approximately 5,300 individuals with spinal or knee impairments. However, as Alan and I began to use the data, it became apparent that the model was not flawless. We discovered quite a large amount of missing data; in fact, complete data were available from only approximately 1500 patients. Many patients did not have any follow-up information at all, and in some practices only a small proportion of patients contributed even initial data. The reasons for missing data in our dataset could not be definitively determined, and we recognized that the high proportion of patients with incomplete data would rightfully raise concerns about the validity of our findings. Herein is demonstrated one of the problems with using clinically derived data for research purposes.

> ...we believe our work demonstrates the potential benefits, in fact the necessity, of belonging to a community of colleagues which assumes responsibility for the outcomes of practice and is involved in a continual search for quality care.

Well, fortunately, we need not rely simply on speculation in determining the source of the problem; we can draw on our own literature. A very nice article in the July 1997 issue of *Physical Therapy* describes the attitudes of clinicians towards standardized data collection. Dr. Russek and colleagues[2] determined that barriers to clinicians' contributing to a database were inconvenience and lack of time, lack of acceptance of operational definitions, lack of training in the use of forms, and lack of supportive personnel to manage the data. These are certainly legitimate impediments for busy clinicians, but assuming a collaborative environment, the problems are potentially addressed by other members of the partnership. For example, administrators can schedule time for training and provide support staff for data management. Additionally, administrators can provide targets for adherence to data collection efforts and the quality assurance and peer review processes can be used to assess how well the data collection system works. Timely implementation of improvements recommended by these processes might also serve to win the support of clinicians. Researchers and clinicians can work together in designing forms, making them user friendly and efficient. Educators can stress to the next generation of clinicians the rationale for standardized examination techniques and emphasize those which are known to be reliable.

It seems to me that clinicians would also have greater vested interest in systematic data collection if the scores from those health status or outcomes measures which required computerized or hand scoring were to be provided to them in a timely manner so that information could be used in decision making for individual patients. Previous literature has suggested that one barrier to use of health status measures in the clinical setting is the lack of usefulness of the information to the clinician. Most PTs, for example, have at least an intuitive understanding of the meaningfulness of a change in muscle strength from 3/5 to 4/5. They would ask, however, what does a change in 5 points on the Oswestry Low Back Pain Questionnaire or a score of 80 on the physical function scale of the SF-36 mean for the patient and how does that affect the goals, intensity, or type of intervention we provide? Researchers must function as part of the team to clarify the meaningfulness of instrument scores and changes in scores. Interestingly, although clinicians may have difficulty incorporating information from measures of function in their decision making, in at least one study, patients whose healthcare providers asked them questions related to information they provided on such a questionnaire were more satisfied with their care than patients whose providers did not ask.

Occasionally, clinicians' needs and institutional needs for data collection may be in conflict. Clarity in setting priorities is essential. Reducing barriers to complete and reliable data collection requires that team members thoroughly understand one another's perspectives.

Finally and above all, we believe our work demonstrates the potential benefits, in fact the necessity, of belonging to a community of colleagues which assumes responsibility for the outcomes of practice and is involved in a continual search for quality care.

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Physical Therapy Evaluation and Intervention for Snapping Scapula Syndrome

By Ron Scott, JD, MSPT, OCS

Snapping syndromes in and around joints are a relatively common phenomena. Significant pain or disability sufficient to warrant operative intervention associated with snapping syndromes are extremely rare. Most often, physical therapists, physicians and surgeons, and other primary health care providers treat these innocuous syndromes in the following ways:

- Advice to avoid specific activities of daily living that cause snapping to occur, and
- Reassurance that the condition is not serious.

Physical therapists caring for patients with snapping syndromes should also consider prescribing appropriate stabilizing exercises to minimize or eliminate snapping scapula, and, after postural evaluation, instructing these patients in appropriate postural corrective measures.

Snapping scapula, or scapulothoracic crepitus, was first described in 1867 by Boinet. Also in 1867, Demarquay described for the first time in the professional literature a subscapular exostosis that he observed on autopsy. In the mid 1900s, Milch contributed several professional literature articles on the snapping scapula, in which he reported that the precise situs of crepitus could be easily localized through auscultation. Milch classified subscapular grating sounds into three types:

- *Froissemant*, or mild, asymptomatic noise, considered a normal physiological consequence of periscapular muscle action,
- *Froittemant*, or moderate grating, with or without pathology, and
- *Craquemont*, or severe noise, which is often the result of pathology, and commonly associated with significant pain and/or functional impairment. [1]

Milch noted that as many as 70% of people experience froissemant.[2] In cases where patients undergoing evaluation display only froissmant and voice subjective complaints of severe pain or dysfunction, physical therapists may need to rule out secondary gain, especially where such patients are in litigation or have pending worker's compensation claims.

DEVELOPMENTAL CONSIDERATIONS

The scapula is formed by endochondral ossification, with the primary scapular body ossification center forming in the seventh week of fetal life. By week twelve of fetal life, the developing scapulae descend to their normal anatomical position on the thorax. By birth, the body has completed ossification. Seven secondary ossification centers subsequently develop. By age 18, the secondary ossification centers at the acromion and superior and inferior angles appear. By age 25, all secondary scapular ossification centers have united with the body. [3]

ETIOLOGY OF SNAPPING SCAPULA SYNDROME OSTEOCHONDROMA (Osteocartilagenous subscapular exostosis)

Osteochondroma is the most common scapular tumor. It also appears, but less commonly, on the posterior second through seventh thoracic ribs, causing snapping of the scapula. This type of tumor occurs as a developmental growth abnormality in children, or is less commonly congenital and hereditary. It is benign bone tumor, and is characteristically covered by a hyaline cartilage cap. The exostosis continues to grow until growth plate closure occurs.[1]

Along with a scapular exostosis, patients with osteochondroma may develop adventitious friction bursae, which can become inflamed and a source of dysfunction. Because the exostosis and resultant bursa are space occupying lesions, affected patients may display mild to moderate pseudo winging of the scapulae. [4] Where a patient with apparent scapular winging is found to have normal serratus anterior muscle strength or function, an evaluating physical therapist might suspect subscapular exostosis.

Subscapular exostosis cannot normally be visualized on an anteroposterior plain radiograph. To best visualize the tumor, a tangential scapular radiographic view and/or CT scan is required. [3]

Surgery to excise a subscapular exostosis is rarely required, and is normally only indicated under the following circumstances:

- In the presence of severe pain and/or dysfunction,
- In the case of a cooperative patient without major psychological overlay, and
- Where appropriate diagnostic imaging studies have clearly identified either an osteochondroma or an inflamed bursa, or both, requiring resection.[1]

Description of a Surgical Technique and Immediate Postoperative Rehabilitation. [5]

- After appropriate skin preparation, the surgeon makes a longitudinal incision at the medial border of the scapula, near to where the exostosis is believed to lie.
- The surgeon then carefully resects the upper trapezius muscle along its lines of muscle fibers (to minimize trauma and postoperative loss of muscle strength) over the superomedial angle of the scapula. Care must be taken to avoid dissecting the upper trapezius too far medially to prevent injury to the spinal accessory nerve.
- The rhomboid major is then freed from the edge of the scapula. The surgeon next dissects the subscapularis and serratus anterior muscles subperiostally, exposing 3 to 4 centimeters of the medial scapula.

The surgeon next uses the following decision algorithm:

- If an exostosis and/or inflamed bursa are discovered, excise them.
- If neither an exostosis or bursa is found, resect a 4 to 5 centimeter triangle from the superomedial scapular angle. The superomedial angle is relatively uncushioned from movement friction by muscle or other connective tissue, and is also prone to be a situs of crepitus because of its slight anterior nutation on the thoracic ribcage. In addition, a fibrocartilagenous nodule, referred to as Luschka's tubercle, is sometimes found at this point.[1]
- After resection, the surgeon smoothes bony margins and approximates muscle that has been disrupted.
- A hemovac suction drain is implanted, and the subcutaneous tissue and skin incision are closed with appropriate sutures.

A postoperative rehabilitation protocol might include:

- Use of a sling for approximately one week,
- Immediate pendulum and Codman's exercises, and
- Commencement of active range of motion in the affected shoulder complex one week postoperatively, when use of the sling is discontinued.

Physical therapists treating these patients may progress them to mild progressive resistance exercise when sufficient soft tissue healing has ensued, at approximately six

weeks postoperatively, at the direction of the patient's surgeon.

OTHER PERISCAPULAR ANOMALIES

Snapping scapula may also result when the scapula(e) are undescended, as in Sprengel's deformity,[6] and in the case of the scapular or rib fracture where callous causes crepitus. Imbalances in periscapula muscle force couples may disrupt normal scapulohumeral rhythm and cause subscapular crepitus, as may muscle avulsion flap tissue (eg, subscapularis or rhomboid muscle). Snapping may also result from neuropathies, including long thoracic neuropathy. Postural deformity, in the form of trunk slouching, may alter the normal anatomical relationship between the scapulae and thorax, causing increased anterior nutation of the superior border of the scapulae and/or lateral migration of the scapulae, with possible resultant subscapular crepitus and irritation.

AGE-RELATED ANATOMICAL AND PHYSIOLOGICAL STRUCTURAL AND FUNCTIONAL CHANGES

Culham and Peat[7] studied 91 women between ages 20 and 85, 23 of whom had a definitive diagnosis of osteoporosis. They noted the following findings, which may predispose to snapping scapula(e):

- Scapular and clavicular retraction compensatory to increased kyphosis, and
- An average increase in normal anterior scapular nutation of from 9 to 13°.

Another important age-related factor that may lead to subscapular crepitus is the thoracic vertebral body anterior wedge fracture, a common sequela of osteoporosis. Culham and Peat noted no significant change in the normal (5 to 6 centimeter) linear distance from the thoracic spinous processes to the medial scapular borders with age.[7]

SUMMARY OF SIGNS AND SYMPTOMS ASSOCIATED WITH SNAPPING SCAPULA(E)

- Localized scapular sounds, with or without pain or dysfunction,
- Sub- or periscapular tenderness to palpation,
- Postural deformity, in the form of:
  - Slouching, and/or
  - Increased kyphosis
- Visible periscapular muscle atrophy,
- Scapular winging with arms at rest and at the sides,
- Decreased scapular mobility with passive mobility testing,
- Decreased shoulder and/or cervical spine active range of motion,
- Disruption of normal scapulohumeral rhythm. (What is "normal" scapulohumeral rhythm is subject to debate. Inman first described normal scapulohumeral rhythm as a 2:1 ratio of scapulothoracic to glenohumeral motion from approximately 30 to 170° of active shoulder abduction.[8] Poppen and Walker[9] reported a 5:4 ratio of scapulothoracic to glenohumeral motion after an initial 30° of exclusive glenohumeral abduction during which the scapula merely sets itself for subsequent motion.), and
- Abnormal lateral scapular glide test[6] measurements, ie, greater than a one centimeter difference between the linear distances from scapular inferior angles to the posterior midline at 30, 45, 90, and 120° of abduction.

CONSERVATIVE INTERVENTIONS

Nonphysical therapy conservative treatments include, among others, prescription of nonsteroidal anti-inflammatory medications and local anesthetic and steroid injections. Orthopaedic surgeons have also proposed specific conservative rehabilitation measures in the literature. Rockwood[1] recommends the use of heat and scapular protection and shoulder shrugging exercises. Crenshaw[5] recommends ice, scapular muscle retraining to restore normal synchronous shoulder abduction, and the possible use of a figure-of-eight sling in cases of bursitis or myalgia.

Physical therapists may also wish to consider the following interventions for patients with snapping scapula(e):

- Postural education and correction,
- Prone press-up exercise to strengthen back extensor muscles and to minimize increased thoracic kyphosis, and
- Progressive resistance exercises, as tolerated, to selectively hypertrophy the subscapularis and serratus anterior muscles to provide a greater cushion between the scapulae and thoracic ribs two through seven. The patient can begin with relatively low-stress brief repetitive isometric exercise and progress to daily adjustable progressive resistance exercise, using gradually increasing amounts of free weight resistance.

As for specific patterns of movement to optimize hypertrophy of the target muscle groups, Moseley [10] has proposed flexion, abduction, and scaption to optimize serratus strength, and Townsend [11] has proposed scaption combined with internal rotation and the military press to optimize subscapularis strength, based on these exercises' observed percentages of a normalization base (maximal isometric contractions as determined by electromyography). These exercises might be utilized in a subscapular muscle hypertrophy program, as tolerated, in progressively more challenging degree ranges of elevation.

Physical therapists may also consider during evaluation of patients with signs and/or symptoms of possible snapping scapula, the use of a scapular compression test (with mild clockwise and counterclockwise grinding) to assess whether a patient with snapping scapula has subscapular tenderness associated with an exostosis, inflamed bursa, or other condition.

CONCLUSION

Snapping scapula, although relatively benign, is a pathology that may be readily amenable to conservative physical therapy intervention. This article proposes a test for subscapular osteochondroma and inflamed bursae, and recommends a course of physical therapy to optimize the strength of serratus anterior and subscapularis muscles to help cushion the deep surface of the scapulae from crepitus. Commentary and further study and reports are invited.

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Review of the United Kingdom Guidelines

By Tony Delitto, PhD, PT

The Royal College of General Practitioners (RCGP) convened a multidisciplinary group of expert practitioners and researchers to develop their version of *Clinical Guidelines for the Management of Acute Low Back Pain*. The publication, dated April 1998, is available in full text through the following web site:

http://www.rcgp.org.uk/backpain/rcbp0005.html

The purpose of this article will be 1) to describe the methodology and outcome of the practice guidelines as they relate to physical therapy, and 2) to offer a brief commentary on the outcome.

General Description of the Methodology

The members of the Guideline Development Group (GDG) included general practitioners, an orthopaedic surgeon, a representative from physiotherapy, and various research associates and fellows. The group consisted of a total of 12 members and 3 "observers." *The RCGP and the Chartered Society of Physiotherapy were listed as "contributing organizations."*

The guidelines consists of four chapters, a list of references and an appendix. Highlights include:

Chapter 1: Methods of Evidence Review and Recommendation Development. This chapter is subdivided into three sections that deal with the guideline development process, evidence review methods, and evidence ratings. The guideline development process lists the GDG as well as an "advisory group" drawn from the RCGP, the Chartered Society of Physiotherapy, the British Chiropractic Association, the Osteopathic Association of Great Britain, a "clinical standards advisory group," (CSAG) and patient representatives from the National Back Pain Association. It is not clear if there were two different groups or if the Development and Advisory Groups were one and the same. The GDG began from where the US Agency for Health Care Policy and Research (AHCPR) Low Back Guidelines left off by systematically reviewing further evidence published since 1993 (the AHCPR cut off) until 1996. They also included works in press, and material from other sources, such as the Cochrane Collaboration on Back Pain. *Four key areas of management were the focus: (1) bedrest, (2) advice on staying active, (3) manipulation, and (4) exercise.* A total of 14 systematic reviews were used in the recommendation process. The reviews that focused on interventions pertinent to physical therapists included: *bedrest* (2 reviews of a total of 14 RCTs); *advice on activity* (1 review of a total of 7 RCTs), *back schools* (2 reviews of a total of 29 RCTs); *manipulation* (2 reviews of a total of 38 RCTs), *back exercises* (2 reviews of a total of 14 RCTs), *ultrasound* (1 review of a total of 2 RCTs), *traction* (1 review of a total of 14 RCTs) and *orthotics* (1 review of 5 RCTs).

The review process used by the group was such that the AHCPR guidelines and recommendations were used as default, and recommendations were only changed if the recently reviewed literature suggested a modification.

Review Methods: Evidence was rated on a three star system as follows:

The Weight of evidence is rated:	
***	Generally consistent finding in a majority of multiple acceptable[1] studies
**	Either based on: (1) a single acceptable study or (2) a weak or inconsistent finding in some of multiple acceptable studies
*	Limited scientific evidence which does not meet all of the criteria of acceptable studies

The document points out the criteria for the AHCPR ratings (a four-level rating system) to illustrate the basis for their own ratings. Their three-star system was implemented partly because the AHCPR panel did not rate anything at the "A" level.

Chapter 2: Evidence Review. Includes Diagnostic Triage and Initial Assessment Methods (x-rays, psychosocial factors, risk factors for chronicity, management, and information to patients), Drug Therapies and "Physical Therapies" (manipulation, back exercises, physical agents, traction, TENS, shoe insoles, lumbar corsets, trigger point and ligament injections, acupuncture, epidural steroids, facet joint injections, biofeedback, and group education back school).

Highlights: Diagnostic procedures and indications for further work-up are similar to findings of the AHCPR panel. In a significant deviation from AHCPR, however, psychosocial factors were listed as: (1) playing an important role in chronic low back pain and disability (3 star evidence), (2) playing an important role at a much earlier stage than previously believed (2-star), and (3) having an influence on the patient's response to treatment and rehabilitation. Also substantially different from AHCPR Guidelines are the acknowledgement of Clinical Features which increase the risk for developing chronic back pain and the acknowledgement that psychosocial features are more important risk factors than biomedical symptoms and signs (2-stars).

Although accurate information on a good prognosis for rapid recovery was consistent with the AHCPR Guidelines, the UK Guidelines go a step further by acknowledging the increased evidence for practical advice to the patient on maintaining daily activities and encouragement to return to work.

Drug therapy: New evidence for paracetamol and paracetamol-weak opiod compounds being prescribed at regular intervals for acute backache was identified. In addition, NSAIDS at regular intervals were found to effectively reduce backache but were less effective for reduction of nerve root pain and symptoms (2-stars), and the use of muscle relaxants (2-stars). There was no change in AHCPR's recommendation against strong opiods. *There was stronger evidence against the use of bedrest.*

Physical Therapies

Manipulation: The UK guidelines first stress that the "systematic reviews" of the RCTs on manipulation sometimes reach conflicting conclusions. On patients with backache (without nerve root involvement), the evidence continues to support the use of manipulation for short-term improvement in pain and activity levels and higher patient satisfaction. *They acknowledge that there is no firm evidence that it is possible to select which patients will respond or what kind of manipulation is most effective. They also note that the risks of manipulation are very low provided the patients are selected and assessed properly and the manipulation is carried out by a trained practitioner. All of the recommendations under manipulation achieved 2-stars.*

Back Exercises: Two major findings to add to those recommendations from the AHCPR Guidelines include: (1) it is "doubt-

ful" specific back exercises produce significant improvement in acute low back pain, *nor is it possible to select which patients will respond to which exercises* (2-stars) and (2) McKenzie exercises may produce some short-term symptomatic improvement (2-stars).

Traction: A 3-star recommendation was given ***against*** the use of traction.

TENS: Inconclusive evidence on the efficacy of TENS in acute back problems (2-stars).

Shoe insoles, lumbar corsets, biofeedback: All of these interventions received 1-star either showing no or very limited evidence of effectiveness.

Because of: (1) no evidence of effectiveness; (2) simpler and safer alternatives and (3) association with potential hazards or complications, the guidelines point out evidence against the following treatments:

- Narcotics for > 2 weeks
- Diazepam for > 2 weeks
- Colchicine
- Systemic Steroids
- Bedrest with traction
- Manipulation under general anesthesia
- Plaster jackets

Recommendations

The guidelines make recommendations based on the following:

- Diagnostic triaging
- Use of x-rays
- Psychosocial factors
- Drug therapy
- Bedrest
- Advice on staying active
- Manipulation
- Back exercises

Highlights: As stated earlier, the acknowledgement of psychosocial factors is probably the most significant addition to the recommendations from the AHCPR Guidelines, where such factors were relegated to only minimal mention. *The recommendations in this area include: (1) that psychosocial assessment, including such factors as psychological, occupational, and socioeconomic factors, should be included in the initial assessment and (2) management and the advice given to patients should consider and allow for psychosocial factors.*

Whereas the AHCPR Guidelines recommended against bedrest, the UK Guidelines appear to make a stronger stand opposing this intervention. Similarly, the AHCPR Guidelines recommended advising the patient to stay active and the UK Guidelines further endorse this approach based on additional evidence favoring this strategy. The strength of the recommendation favoring manipulation appears to be about the same as the AHCPR, with the small exception that it is recommended for patients who, within the first 6 weeks, "need additional help with pain relief or who are failing to return to normal activity." The UK recommendation appears to be even stronger against the use of specific back exercises than that of the AHCPR Guidelines.

Commentary

I would like to focus my comments in the general area related to defensible practice and on a few specific areas related to the UK Guidelines. First, our profession is once more getting another "taste of things to come" with regard to defensible practice. Again, the onus will be placed on us to determine which interventions are effective in managing a specific entity. In the case of low back pain, which accounts for a high percentage of our care, we should be most interested in which treatments are effective. Effectiveness must be based *on a currency that is universal.* The UK Guidelines once more point out what makes up that currency. That is, published, peer-reviewed, randomized clinical trials. As a profession, I would hope we are past the stage where we think whining very loudly will cause others to listen to our various cause(s) for continuing to embrace some of our "favorite" interventions in spite of the evidence against same. I believe such whining only detracts from our own credibility and reduces the chances that anyone participating on such consensus panels will take our concerns seriously.

There are some very specific points about the UK Guidelines that I think should be looked at much more closely. Unlike the AHCPR Guidelines, there is at least a hint in the UK Guidelines that there may be subclasses of patients who will differentially respond to treatments. Specifically, under manipulation and back exercises (McKenzie exercises), the UK Guidelines state that there is no evidence that it is possible to select who will be positive responders to such interventions. In my opinion, this is a point that should hit home with most physical therapists. Who is in the better position than physical therapists to determine indications (and contraindications) to such treatments. On a daily basis, we are making clinical decisions to use manual therapy procedures or McKenzie exercises on certain subtypes of patients? We are the only profession that has, through the peer-review process, identified a need for classification of patients with low back problems **and** offered models for the same. Such groundwork, while not at the stage where it can be recognized by panels, nonetheless places us much closer than any other profession to answering the questions posed by the UK Guidelines dealing with indications for manipulation or exercise. I would anticipate such answers are right around the corner and, once published, should certainly have an influence on subsequent guidelines.

My final comment deals with the systematic reviews of the literature that were too heavily depended upon not only by the UK Guidelines, but by virtually all other clinical practice guidelines. Physical therapists need to closely review the criteria for such guidelines and understand that the decision of what will be used for criteria and how that criteria will be weighted is often very arbitrary. This may explain why systematic reviews of the same material (eg, studies on manipulation) may lead to different conclusions! Certainly, systematic reviews can take on a very epidemiological slant where overall design, threats to internal validity, and other methodological criteria are weighted much higher than practical and clinically relevant criteria, such as the generalizability of the treatments themselves. For example, there are numerous instances where systematic reviews of RCTs related to "back exercises" scored very highly. This occurred because of a review criteria that rewarded very heavily epidemiological criteria. Yet, in both cases the studies have been criticized because both of the exercise regimens used would very rarely, if ever, be prescribed by anyone dealing with patients with acute low back problems!

In these cases, the point is not to dismiss the particular systematic review. Rather, I would propose that a systematic review be undertaken once again and add criteria related to clinical relevance. Such a review can certainly be undertaken in part by the APTA or one of its components (eg, the Orthopaedic Section), preferably with another organization (eg, American Academy of Orthopaedic Surgeons). In fact, with budget cuts at the AHCPR it has been suggested that Clinical Practice Guideline development be undertaken by professional organizations and societies. To maintain credibility, the review would require the participation of a multidisciplinary team of specialists (just like the AHCPR panel or the UK Guideline development panel). Finally, such a review would need to be published in peer-review format. It would be most interesting to see how recommendations may change with such a strategy.

Tony Delitto, PhD, PT is Associate Professor and Chair of the Department of Physical Therapy at the University of Pittsburgh.

Letter to the Editor

Alicia Dittmar, MEd, PT presents a timely topic in her article *Clinical Problem Solving and Physical Therapist Assistants, Orthopaedic Physical Therapy Practice*, Winter 98. Her article highlights the urgency for the profession to further clarify the role of the PTA. Ms. Dittmar outlines clinical decision making and compares the decision making of PTs and PTAs. She seeks to develop "relationships" and "partnerships" with PTAs while espousing a rationale to evolve PTAs into professional clinical decision makers. This rationale is flawed, based on suppositions and is not consistent with the profession's statements on the role of the PTA.

Upon review of the core practice documents of our profession,[1-5] not just the ones cited by Ms. Dittmar, I would offer a different perspective. Physical therapists are autonomous health care providers with a scope of practice. This distinction is based on the education and training received prior to licensure and the subsequent passing of the licensure examination. I could take all the orthopaedic surgery continuing education courses available and an orthopaedic surgeon may think I am qualified to practice orthopaedic surgery. Does that qualify me to perform arthroscopic surgery? Does that allow the orthopaedic surgeon to "promote" me to the practice of orthopaedic surgery? Never!

Why are there such limits on every health care provider? They are there to protect the public. It is the state's role to determine the limits on an individual's license. PTs do not have the legal authority to expand the role of the PTA. The legal and ethical limits on the duties of the paraprofessional PTA are determined by the technical education and training received prior to licensure (where applicable.) Let's look at this education for a moment.

PTA educational programs are technical not professional education. This distinction is the fundamental difference between PTs and PTAs. So what is the difference? Paraprofessionals are taught only basic decision making skills. PTAs make decisions that involve very specific and limited boundaries set by the treatment plan. The treatment plan should be specific enough that PTAs are not asked to make decisions beyond the scope of their education and training. In addition to instruction in performing treatment tasks, PTAs are primarily taught to gather information and relay it to the PT. They are not taught to analyze the information they have received. PT education involves not only gathering information but also synthesizing it and making complex decisions based on variable and multifactorial data. These decisions are borne solely by the PT.

Unfortunately there has been an inadequate definition of PTA education and as a result there has been variations in the content of PTA educational curriculums. As a result many programs have attempted to push the envelope in PTA education. Ms. Dittmar gives an excellent example in her article. "Many are also taught how to develop short term goals (STG) regarding this data when given a functional, long term goal statement generated by the physical therapist." When the APTA documents[1-6] are reviewed it should be clear that it is inappropriate for PTAs to develop STGs. The process used to develop STGs involves much more than knowing "a functional, long term goal." To develop a STG the physical therapist uses all the information gathered and synthesized in the examination, evaluative and diagnostic process. The setting of goals is one of the highest levels of decision making in physical therapist practice.

The APTA is developing the *Model for PTA Education*. This project is critically important in determining what is taught in PTA education programs. The Model should eliminate the variations in PTA education. Graduates of accredited programs will receive a standardized education. This standardization is necessary to protect the public. The consumer has the right to be assured that every PTA has met the same minimal educational standards.

Why are there attempts by some of us to try to inappropriately expand the role of the PTA? From my perspective this behavior comes primarily from two sources. The profession as a whole invites this behavior by not clearly defining the boundaries of PTA education. The *Model for PTA Education* should go a long way to readdressing the educational component.

For the other component of this behavior we must look to each PT and PTA. We must review the existing laws and regulations governing our practice and the practice documents of the APTA.[1-6] We must stop trying to treat PTAs as equals or partners. Valued associates, highly skilled paraprofessionals, and a member of the team – yes. However on each team there are different roles for each player. We can not change the role of the PTA based on our friend and coworker who may be a highly skilled PTA with the potential to further develop.

Some of the greatest attributes of PTs and PTAs are their respect for the dignity of humans, their skills as teachers, and the desire for each individual to achieve their maximal potential. Unfortunately, these attributes are misused when we try to make a PTA into something they are not. Our efforts should be to encourage the PTA to participate in the role they chose or to return to school to expand their role ethically and legally. Let us not forget many, if not most, PTAs do not want an expanded role. They feel uncomfortable in having expanded roles thrust upon them. PTAs should articulate their concerns when they are asked to inappropriately expand their roles. If we recognize the inherently limited role of the PTA and work toward improving their technical skills and not more, than we will do much to improve the quality of care of our patients and truly work as a team.

1. APTA *Code of Ethics.*
2. APTA *Guide to Professional Conduct.*
3. APTA *Guide to Conduct of the Affiliate Member.*
4. APTA *Standards of Practice and the Criteria.*
5. APTA *Guide to Physical Therapist Practice, Physical Therapy* Nov. 97.
6. APTA House of Delegates Policies including, *Direction Delegation and Supervision in Physical Therapy Services.*

Doug M. White, PT, OCS

Response

Alicia R. Dittmar, Med, PT

Thank you for this opportunity to reply to Douglas White's response to my article Clinical Problem Solving and Physical Therapist Assistants. Mr. White is just the sort of conscientious professional for whom I intended this article. I could not agree more with him that there is an urgent need within our profession to define, debate, and develop some consensus regarding the evolving roles of BOTH the PT and the PTA. Unfortunately, I believe Mr. White missed the point entirely of my ar-

ticle and am grateful to have this chance to further clarify my opinions.

In his response, Mr. White seems to focus solely on the issue that PTs are the professionals and PTAs are not. We have had that tired, "been there and done that" discussion before. It has served our profession not one bit but to drive a wedge between many a PT and PTA. Nowhere, in my article did I suggest that a PTA become or be treated as a PT. PTAs do not indeed wish to be viewed as "Jr. PTs." Just as I would doubt that any PT should wish to be considered a "Jr. Orthopaedic Surgeon." They lack the license and educational credentials to do so. What a scary legal nightmare that would be. PTAs wish simply to be treated and respected as the valuable, skilled, knowledgeable members of the treatment team that they are. According to Webster, [1] partners are persons who take part in a common or shared activity, an associate. I still contend that the relationship between a PT and a PTA is one of a trusted partnership, a shared desire to provide the best care possible for their common clientele. A partner but not an equal. For PTAs are both legally and ethically responsible to the client and the PT, just as a PT is responsible to their client and their referring physician where applicable. The value of each is not diminished by the supervisory role of the other.

Mr. White sites several documents printed by the APTA regarding the role and function of the PTA. [2-7] Attempting to point out their limited practice scope, he writes "paraprofessionals are taught only basic decision making skills." This is in fact supported clinically by the *Guide to Physical Therapist Practice:* "The PTA may modify a specific intervention procedure in accordance with the changes in patient/client status and within the scope of the established plan of care." However, in a subsequent sentence Mr. White writes "PTAs are primarily taught to gather information and relay it to the PT. They are not taught to analyze the information they have received." Not only does he contradict himself and the opinion of the profession, but he relegates the PTA to the role of "labrador retriever" of the profession. "Fetch the paper, REX, but do not read it." The point of my article was to inform therapists like Mr. White that PTAs can and do think about the data gathered during a treatment session toward the goal of improving communications with the supervising PT. PTAs performing goniometric measurements of the shoulder, finding abduction to be 45 degrees, would know that that is not a normal measurement. PTAs treating an acute THR patient complaining of calf pain, finding redness, swelling, tenderness not present in that morning's treatment would know that the patient status had changed sufficiently to discontinue therapeutic exercise and gait training and alert the evaluating PT. These PTAs are not expected to re-evaluate their patients nor determine/document "WHY," although they may have some ideas about that. The determining of "WHY" (which is a complex act of synthesizing multi-factorial information and generating complex decisions) and major programmatic modifications is the role of the PT. PTAs who gather patient information and present a clear idea of what is not normal to their supervising PTs go a long way toward improving the efficiency and effectiveness of the PT.

Mr. White also takes issue with the idea that PTAs can formulate ideas about short term goals toward the goal of improving communication between the PT and the PTA. He seems to think that this is not only illegal, but also unethical. If Mr. White would review several state practice acts, he would find no such language about the role of the PTA in the formulation of STGs. I have previewed several state practice acts, in the course of graduate work and having practiced or supervised student practice in many states. The language of most state practice acts is left intentionally vague or is conspicuously lacking in this and many other areas in order to allow supervising PTs the autonomy to decide how best to manage their practice. I do not think that we want a large government bureaucracy dictating the fine details of our community usage patterns. This is what I refer to as the expanding supervisory roles of the PT: determining if and when a certain patient or treatment would be appropriate to delegate, given the skill level of the PTA and the critical nature of the patient. Having a PTA write a STG is not illegal.

Now, is it unethical according to the APTA? After studying the documents mentioned by Mr. White, I think not. Certainly it is not the role of the PTA to write the initial plan of care including long and short term goals. This would not only be illegal in the practice acts I have studied but also unethical according to the *Guide for Professional Conduct*. However, I do not see how knowing that your goal for the day is to "ambulate Mr. X 15' more than yesterday" requires a PT's input. In fact, PTAs are expected to process a patient through there established plan of care or quickly alert their supervising PT if they cannot. How can PTAs progress or "modify a specific intervention procedure" if they have no updated short term goal in mind? And what if the patient meets the established STG? Is the PTA to continue with the rote treatment until the next re-eval? In deference to Mr. White, he may have thought that I advocate for all PTAs to write STGs after collecting patient information, even if the STGs were to differ from those originally written by the supervising PT. Again, I reiterate the goal of being able to generate ideas about specific treatments or formulating ideas for STGs is to improve communications and foster respect and trust between the PT and the PTA.

Mr. White and I both look forward to the final APTA consensus document "A Normative Model of Physical Therapist Assistant Education." I hope this document is previewed and discussed in abbreviated format in all PT schools. Having seen initial drafts of this document, I think Mr. White and others may be surprised at the critical thinking and problem solving components associated with PTAs. This is a BASIC skill requirement of PTA curriculums albeit nowhere near as thorough as that required of PT graduates. But even with those minimal requirements of a graduate PTA, I would hope Mr. White would keep in mind the "bell curve" of human behavior. Just because problem solving and critical thinking are minimal or basic or limited at graduation does not mean that a PTA cannot sharpen this process, become more than the average or the "mean" of the curve with time and clinical experience. I suspect that Mr. White has continued his professional development over the years and practices way above the "norm" of minimal standards with which he graduated as a PT. I also suspect that those with whom he works: patients, physicians, nurses, family members, other therapists, etc. all have gained from his new knowledge and skills. I doubt he will attempt any orthopaedic surgery any time soon, that is not his role. I would hope he would accord the PTAs with whom he works the same respect for new knowledge and skills gained and not accuse them or anyone else of attempting to become something other than the best PTA they can be. I do not see this process as expanding the role of the PTA, but rather one of expanding the role and function of the PT.

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1. 1996, Webster's Dictionary.
2-6. Previously cited APTA documents.
7. January 1998. APTA: A Normative Model of Physical Therapist Assistant Education.

The Physical Therapist Assistant in Orthopaedics: Education and Practice

Melinda L. Merrigan, MEd, PTA

This column is geared toward the physical therapist assistant and is being coordinated by Gary Shankman, PTA, ATC, OPA-C.

While the role of the physical therapist assistant (PTA) is being debated within the House of Delegates of the American Physical Therapy Association (APTA),[1] the reality is that PTAs are being utilized throughout the country in a variety of clinical settings. As Blair J. Packard, MS PT acknowledges in his recent article regarding the role of the PTA, "It is in the clinic that physical therapists and physical therapist assistants have the best relationship."[2] He maintains that the clinical relationship is far better than the PT/PTA relationship sometimes seen "in the arena of Association governance, where the forum exists for talking, and sometimes arguing, about the domains of governance, regulation, education and practice."[2]

In many orthopaedic practices, the physical therapist assistant is a vital member of the rehabilitation team who is expected to deliver quality treatments to the patient. PTAs need to have the technical skills to deliver these treatments, as well as the critical thinking skills necessary for proper patient care. As Gary A. Shankman, PTA, ATC, OPA-C, and author of *Fundamental Orthopaedic Management for the Physical Therapist Assistant*, points out "Although direct patient supervision is frequently the task of one individual, responsibility for a patient's care is shared by the entire rehabilitation team."[3]

The amount of time a student has within a PTA program to learn basic physical therapy techniques and skills are, of course, limited. However, to become good clinicians, PTAs must continually develop their skills and techniques. I wanted to talk with PTs and PTAs working in orthopaedic practices about how their skills are developed. How much can be taught in a two-year PTA program and how much must come from the experience of working in the field? Are schools teaching what PTAs need to know to work in orthopaedic practices? In the face of changes within the field, how do PTA programs and educators stay current with orthopaedic practice?

Dave Erickson, MSPT is the current program director of the PTA Program at St. Petersburg Junior College, St. Petersburg, FL. This program has been in existence since 1968. The program's goal is to provide students with a strong foundation to support them in a variety of clinical areas. Erickson says, "They work hard to get basic principles down and have a broad base of knowledge. Students may only be introduced to topics such as joint mobilization, but will not be expected to have a competency in them at the time of graduation." On-the-job training and continuing education are necessary for anyone in the field today. The PTA students in the SPJC-PTA program do take an orthopaedics course that is taught by a PT who is in orthopaedic practice. This assures that students receive information about the current topics in orthopaedics and that their teachings are based on practical skills that they will use in the future. As new instructors come in to teach the orthopaedic course, there is an update of the syllabus that allows the program to stay current with clinical practices. Feedback from educational experiences in the clinic also allows coursework to be re-evaluated for its relevance to the workplace.

Some programs have taught orthopaedics as an integrated course. Through experience and feedback from clinicians and students, many have found it works best for the students if they have a specific orthopaedic course with a concentrated orthopaedic lab. Joyce M. Peters, PT and PTA Program Chair, Endicott College, has found this to be a better approach for their students. Endicott hires an adjunct faculty member which allows students to be educated in the most current standards in the field.

One issue that continues to be raised in PTA education is the unavailability of appropriate textbooks for PTA students. One of the factors motivating Lynn Lippert to write *Clinical Kinesiology for Physical Therapist Assistants*,[4] was the lack of material geared to an assistant's education. In his book, Shankman has taken care to "focus on fundamental, basic, scientific principles, as well as on clinical application of physical therapy interventions related to the scope and use of the physical therapist assistant."[3]

As a PTA, as well as a PTA educator, I am well aware of the differences between theory and practice. While trying to educate future PTAs we often speak of the need to teach our students the best ways of practice, while acknowledging that "in the real world" there is much more that they will have to learn. So, how does the education of the PTA hold up in the transition from student to employee?

Tony Eberhardt, PT II, NH Sports Medicine and Knee Surgery, has a small practice in Bedford, NH in which he utilizes a PTA as well as an athletic trainer (ATC). He employs a team approach and has the expectation that the PTA, at entry level, "will be able to progress patients through their programs, recognizing progress as well as areas of caution and be able to make minor adjustments in the treatment as needed." With continuing education and on-the-job training he feels that if a PTA is "proficient in certain skills, they should be able to perform those skills." He realizes that as a PT and a supervisor of PTAs he is responsible for working closely with his team members to ensure that they become proficient in those skills and feels confident that his employees are effective in the provision of patient care in his practice.

Ron Fuller, PTA, ATC, who works at Healthsouth Rehabilitation Hospital in Concord, NH expresses some of those same sentiments. "As a PTA, you are only limited by yourself. Within your scope of practice you can excel. You must make that jump." Ron was educated as a PTA through the Navy and feels that he was extremely fortunate to have been exposed to many clinical experiences within that military training. He also admits that in spite of his clinical education, he experienced that "inept" feeling we all have when confronted with that first real patient. Ron puts great stock in on-the-job experiences and training he has received over the years, as well as the concept of the PT/PTA team. "I've been lucky in being able to work with knowledgeable PTs who were willing to share their knowledge with me."

Pete Jernigan, PT and owner of Jernigan Rehabilitative Services, Inc., St.

Petersburg, FL, employs 2 PTAs and 2 PTs full-time in his outpatient practice. The PTAs with 13 and 10 years experience, are "expected to carry their own load." Again, they work closely with the PTs in utilizing a team approach to patient care and supervision. He also credits continuing education and clinical experience as a determining factor for what the PTA does in practice.

Pam Turner, a PTA for 19 years and currently employed at CPTE/Nashua, NH sees mostly orthopaedic patients. She works side by side in the gym with PTs and performs the same treatments: "joint mobilization, closed chain exercises, modalities, functional activities, stretching, and PREs." She is able to consult with her supervising PT on site if necessary and has been able to work with "capable PT supervisors" in a team approach which has aided her professional growth. While her education gave her the basic skills she needed she found that as an entry-level PTA, the opportunity to work with a PT who allowed her to develop confidence in her clinical skills increased her own level of proficiency. She maintains that "open communication is the most important thing." Pam also believes that continuing education is a necessity. And over the years, she has seen many changes in the orthopaedic setting of physical therapy; including the obvious changes such as modalities used, managed care and insurance issues, as well changes regarding how one views the patient-from looking at the patient as "just a shoulder" (without incorporating the rest of the person) to learning to treat and engage the whole person. "Critical thinking and the ability to know your limitations," she says, "are a must for the PTA."

Shankman writes of the need for communication and teamwork, emphasizing the "need for immediate, open, accurate, and purposeful communication between all members of the team."[3] He describes those team members as the physical therapist assistant, physical therapist, physician, patient, and others is made clear to highlight the interdependence of all team members in patient care.

The common themes heard from educators and clinicians, both PTs and PTAs, are the need for communication, a willingness to challenge themselves and others in learning, and the need to develop critical thinking skills, to allow for growth as a PTA in orthopaedic practice. A good PTA must develop the ability to be more than a technician, and be committed to professional growth throughout one's career. Continuing education, on-the-job training and experience, as well as a strong cooperative relationship with their supervising PTs will allow them to evolve professionally. Graduation from an accredited PTA program is only the beginning.

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Abstracts and Book Reviews

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

BOOK REVIEWS

Shankman GA. *Fundamental Orthopedic Management for the Physical Therapist Assistant*. St. Louis, MO: Mosby; 1997.

The purpose of Fundamental Orthopedic Management for the Physical Therapist Assistant was to provide a comprehensive orthopedic text written specifically for the PTA student and the practicing PTA clinician. In addition, the book was developed to enhance the concept of communication and teamwork for the Physical Therapist Assistant since individual patient care and orthopedic management have changed in the newer system of managed care.

The book consists of eighteen chapters grouped into four parts. Part one introduces the PTA's responsibility to supervision, modification, or adjustment procedures in conjunction with the physical therapist based on specific responses and keen observations of the patient. This part also address the skills of flexibility, strength, endurance, balance, and coordination, with specific references in applying those skills to orthopedic physical therapy. Part two is a review on the healing processes of ligament, bone, cartilage, muscle, and tendon, how each remodel at different rates, as well as factors that negatively influence healing. Emphasis on the relationships of injury, disease, surgery, and immobilization to restoration of motion, strength, and function are provided in this section. Part three consists of gait and joint mobilization techniques. The reader is introduced to proper gait pattern instruction, weight-bearing status, and the identification of gait abnormalities. The chapter on joint mobilization clearly identifies the role of the PTA in assisting the physical therapist with delegated techniques.

The foundation of this text appears in part four which includes seven chapters on orthopedic management of the foot and ankle, knee, hip, spine and pelvis, shoulder, elbow, and the wrist and hand. These chapters focus on mechanisms of injury, fracture classifications, clinical features of common and uncommon injuries, specific diagrams of surgical procedures, common mobilization techniques, and rehabilitation through criterion-based programs.

Fundamental Orthopedic Management for the Physical Therapist Assistant is a well written comprehensive text. It is clearly organized and easy to follow. This would be an excellent resource book for your personal or department library. A student workbook also accompanies this text that not only benefits the PTA student, but is an excellent tool for clinical instructors as well.

Andrew J. Macfarlane, PTA

Shepard K, Jenson G. *The Handbook of Teaching for Physical Therapists.* Butterworth-Heinemann; 1997.

The Handbook of Teaching for Physical Therapists is a comprehensive text that provides an in-depth look at various aspects of teaching and learning in physical therapy. It comes at a crucial time of high demand and high expectation in the everchanging world of health care where it is no longer sufficient merely to treat patients. Now, more than ever, the expanding role of physical therapy requires embracing new teaching and learning paradigms that no longer focus on disease and illness, but also on wellness and prevention.

The first half of the handbook is centered around teaching physical therapists and physical therapist assistants in the academic, clinical, and advanced residency settings. It provides a broad overview of the history and process of curriculum design including course content, conflicts between professional and liberal arts education, techniques for teaching to facilitate collaborative learning, strategies to enhance clinical reasoning, and professional affiliation.

The second half of the handbook takes a closer look at the role of physical therapists and physical therapists assistants as teachers and the role of patients as learners. This section offers a wealth of resources that would prove helpful to any clinician in any setting. It addresses removing barriers to treatment, motor learning/performance, variables that influence learning, teaching patients/families and community health education.

Finally, in the last chapter Geneva Richard Johnson, PhD, PT, FAPTA provides an insightful vision of the future of physical therapy regarding education, foreign service, practice environments, research, and technology. It strikes a delicate balance between learning from our past and looking forward toward challenges of the future, a future that is truly in our hands.

Sandi Smith, PT

ABSTRACTS

Shields RK, Heiss DG. An Electromyographic Comparison of Abdominal Muscle Synergies During Curl and Double Straight Leg Lowering Exercises with Control of Pelvic Position. *Spine.* 1997;22(16):1873-1879.

Dynamic stabilization exercises that include abdominal strengthening are often recommended to create greater stiffness in the trunk by increasing intra-abdominal pressure or by increasing tension of the lumbar dorsal fascia. The purpose of this study was to compare the EMG activity of abdominal muscles between the isometric bent knee curl and the double straight leg lowering (DSLL) exercises while controlling trunk and pelvic positions. An additional purpose was to determine if specific abdominal muscle synergies could be identified for each exercise.

Fifteen healthy male subjects volunteered. Surface electrodes were used to evaluate the rectus abdominis (RA), the external oblique (EO), and internal oblique (IO) muscles. An electrical goniometer monitored the anteroposterior angular position of the pelvis during the curl and the DSLL exercises. Subjects performed three maximum voluntary isometric contractions of the abdominal muscles in a curl exercise position. Next, they performed a DSLL exercise with the initial position of the hips in 90(of flexion with the knees slightly bent. The legs were slowly lowered until unable to maintain the pelvic position and the EMG activity was measured.

Results demonstrated the mean EMG

activity for the EO and IO muscles were greater during the DSLL exercise compared with the curl exercises. There was a greater effect of the DSLL exercise on the magnitude of EMG activity. Equal activation occured between the RA and the EO and betwen the EO and the IO during the curl exercise. Two dominant synergies were noted during the DSLL exercise. However, to perform the DSLL exercise with controlled pelvic position, there were high levels of EO and IO muscle participation, but it was achieved with or without significant contributions from the RA.

The study determined that the DSLL with a posterior pelvic tilt is more effective than the bent-knee curl for abdominal muscle co-activation in an exercise program. Further studies are needed to focus on patients with low back pain to determine if other muscle strategies are present.

Sylvia Mehl, PT, OCS

Insalata JC, Russell FW, Cohen SB, Altchek DW, Peterson MG. A Self-Administered Questionnaire for Assessment of Symptoms and Function of the Shoulder. *J Bone Joint Surg.* 1997;79A(5):738-748.

This questionnaire was developed to present a self-administered assessment of symptoms and function of the shoulder and to report the results of a prospective evaluation of its validity, reliability, and responsiveness to clinical change.

The Shoulder Rating Questionnaire includes six separately scored domains: global assessment, pain, daily activities, recreational and athletic activities, work, and satisfaction. A final nongraded domain was used to allow patients to select two areas in which he or she believed improvement was most important.

The global assessment domain (Question 1) consists of a ten centimeter long straight line with extremes defined at each end; at left 0 being very poorly to 10 at right being very well. The other domains consisted of a series of multiple-choice questions (Question 2 to Question 20), and the nongraded importance domain (Question 21). Total possible score ranged from 17 to 100.

The population consisted of 100 patients, 73 male and 27 female. The age of the patients ranged from 15 to 71 (average being 40 years). The patients were divided into four groups on the basis of diagnosis: glenohumeral instability, impingement syndrome, complete tear of the rotator cuff, and osteoarthritis of the glenohumeral joint.

Internal consistency was assessed by calculating the Cronbach coefficient alpha for the entire scale and for each domain (Cronbach alpha range: 0.71 to 0.90). Reproducibility was evaluated in a group of 40 clinically stable patients who repeated the Shoulder Rating Questionnaire after a mean of three days (Spearman Rank Correlation Coefficient range from 0.81 to 0.96; Spearman-Brown test-retest analysis ranged from 0.94 to 0.98; weighed kappa value for each question ranged from 0.71 to 0.97).

The Shoulder Rating Questionnaire was able to detect significant improvements in the total score and in each domain score. The responsiveness of the Shoulder Rating Questionnaire compared favorable with several health status questionnaires, and appears to be applicable to the broad range of disorders related to the shoulder. The Shoulder Rating Questionnaire showed to be valid, reliable, and responsive to clinical change, the criteria that is required to become a standardized method for assessment.

Soloman Joseph, Msc, MPT

Volunteers are needed.

If you are interested in writing article abstracts or book reviews, please contact Michael J. Wooden at 770/496-1693, or e-mail at mwooden@mcimail.com

Asian Malaise Closes Curtain on Otherwise Good Year for Investors

By Fred Fletcher

An old adage about the shifting of power in the world's economics goes like this: The Mediterranean is the ocean of the past, the Atlantic is the ocean of the present, and the Pacific is the ocean of the future.

But if comments about the year 2000 marking the beginning of the "Pacific Century" are indeed accurate, we must first apply another old adage: It's always darkest before the dawn.

A $55 billion bailout package was announced in December by the International Monetary Fund (IMF) and accepted by the government of South Korea. It is the largest such rescue package given by the IMF to any government in history.

Moreover, it follows on the heels commitments made by the IMF to Indonesia of $40 billion and Thailand of $17.2 billion, two other would-be "Asian tigers" in the now financially-troubled region.

We thought the events leading up to this point, from a Korean economy which grew to become the world's 11th largest, would make for particularly interesting reading.

A Funny Thing Happened on the Way to the Bank

When a country finds itself in an economic crisis - and "crisis" is an appropriate description - banking problems are often at the heart. Certainly South Korean banks were in business to make money by loaning money, but it's the people to whom they loaned it and the way they went about the loans causing most of the current trouble.

The South Korean model for economic prosperity in place since at least the end of their war with North Korea - called for growth to be driven by a select number of conglomerates, known as chaebol.

These huge, family-owned organizations had their fingers in virtually every sector of the South Korean economy-because they could afford to. Korean banks, directed by the Korean government, kept the capital flowing to finance the growth of these super corporations, and in turn, the growth of the economy as a whole.

It worked well for a while. In the 1980s, the Korean economy grew at a 10 percent annual clip. It was a bit lower in the 1990s, but still impressive. The problem was the mountain of debt that went along with the growth. The current debt-to equity ratio of the 30 largest Korean conglomerates is 5 - 1. That compares with a 1 - 1 ratio with their counterparts in the USA.

Moreover, as instruments of the economic machine, Korean banks were directed to loan money on the basis of chaebol political clout, not on the creditworthiness of any proposed venture. The crisis became international when short term loans were coming due, and the chaebol were no longer afforded the needed credit by banks outside the country to pay them off.

Hence the IMD's involvement with an unprecedented bailout plan, both in terms of its size and the measures with which it will be implemented.

Among the requirements the IMF is imposing are:

- A cut in public spending and slow spending on investments
- An increase in excise and other indirect taxes
- Relaxing import limitations
- Allowing international investors to own 50 percent or more of Korean companies
- Allowing foreign banks access to the domestic market

But, as we all know, change is difficult to adopt even when it looks like it's for the better. Already two ends of the spectrum are emerging.

"Please understand the necessity of the economic pain we must now bear and overcome." This from Lim Chang Vuel, Korea's minister of finance and economy, representing the "enduring pain now will help us in the future" point of view.

On the other side of the ledger may well be the Korean citizens themselves, who had very little control over the bad decisions which led to the current situation and whose view might easily be summed up by the *Korean Times*' description of the decision to seek help: "galling."

Knowing that average annual compensation went from $80 to more than $10,000 in just four decades and workers in this economy were all but guaranteed a job for life, gives us a little more perspective on their current unhappiness.

But a theme we hammer on continually is worth repeating here: It is now a world economy. We couldn't be more excited about the outbreak of global capitalism because we believe it to be the best way for the most people to prosper economically. But it is not without pain as it has a way of ensuring only the most efficiently equipped competitors remain competing over the long haul. And in Korea as well as the rest of Asia if the commitment is to the long haul, the days of the chaebol and inefficiencies it wrought are coming to a close.

This article is for general information only and is not intended to provide specific advice or recommendations for any individual. Consult your financial adviser, attorney, accountant, or tax adviser with regard to your individual situation.

Fred Fletcher is an Investment Executive who provides investment advice to the Orthopaedic Section, APTA. If you would like additional information, please contact Fred through the Orthopaedic Section office.

Paul Howard Receives Award for Excellence in Teaching Orthopaedic Physical Therapy

Paul D. Howard, PhD, PT, CertMDT is the 1998 recipient of the Award for Excellence in Teaching Orthopaedic Physical Therapy. Paul is an Assistant Professor in the Department of Physical Therapy at Thomas Jefferson University where he is the primary instructor for the basic and advanced orthopaedic physical therapy courses and the advanced clinical dissection course. Paul received his BS, MS, and PhD degrees, all in physical therapy, from New York University. He is regarded by both colleagues and students as having an expansive knowledge base, a clear and concise teaching style, a strong work ethic, and tremendous compassion and concern for his students.

Paul works closely with the basic science instructors to improve the clinical relevance of the courses to the students. He is well known among his students for his unique ability to take a difficult and complex subject and break it down to its appropriate elements for complete integration and understanding by the students. He is highly regarded as a role model and mentor by both current and former students. He continues with an active clinical practice in the evenings and on weekends while maintaining his full time teaching position.

Paul is recognized by both colleagues and students for his strong commitment to educating physical therapy students and thereby strengthening the profession of physical therapy. The Orthopaedic Section is pleased to present Paul Howard with this award.

Outstanding Physical Therapist Student Stacy L. Procopio

Stacy L. Procopio is this year's winner of the Outstanding Physical Therapy Student Award. Stacy is a member of the class of 1998 in the School of Physical Therapy at Slippery Rock University. She received the award of Outstanding PT Student at Slippery Rock for two consecutive years and was recognized as having the highest cumulative grades in the program. In addition to her academic excellence, Stacy found the time to serve as her class secretary for two years and received a graduate teaching assistantship in Gross Anatomy that required twenty hours per week of her time.

Stacy has also managed to remain very active in community activities while in physical therapy school. She volunteered to help flood victims in the Pittsburgh area, presented a postural awareness program to local nursing home residents and coordinated the 1997 Annual Workers' Compensation Seminar at a local hospital. She participated in fund raising efforts for the Pennsylvania Chapter to assist in covering legal expenses from recent litigation with the Chiropractic Association.

Stacy's student research project received funding from the State System of Higher Education and was presented as a platform presentation at Combined Sections Meeting. She is anxious to become involved in Association and Section activities and is certainly a worthy recipient of this award.

Student Guest Winner '98
Heather Smith

PROFILE

Educational Background: Bachelors of Science - Psychology, Indiana University - Bloomington campus; Bachelors of Science, Physical Therapy - Indiana University - Indianapolis campus.

Special Honors: Received an Allied Health Scholarship while in physical therapy school.

Home: Portage, Indiana

Hobbies: Enjoys running, rollerblading, hiking, camping, spending time with her dog and cat

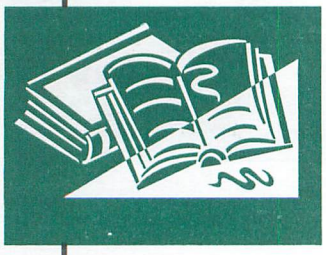
Why did you choose physical therapy? She has always been interested in her own health. Originally she pursued a pre-medical degree in school, and then she decided to volunteer in a hospital and was an aide in an outpatient facility for 4 years. She enjoyed her volunteer work, and therefore decided to switch to physical therapy.

Anticipated Professional Setting: Outpatient (orthopaedic setting) facility

Affiliations: Outpatient setting - NovaCare, Feeding Hills, MA; Acute Care setting - Methodist Hospital, Merrillville, IN; Outpatient setting - HealthSouth, Palm Bay, FL (current); Outpatient setting - Kokomo Rehabilitation Hospital, Kokomo, IN.

What she liked the most about CSM: Enjoyed meeting lots of people and liked spending time in the Research Platform sessions. She enjoyed hearing the research findings presented during these sessions.

What she liked least about CSM: By the end of the day she was pretty tired!



Section History

The Section office is looking for photos, articles and any other information relating to Orthopaedic Section History for our archives. Please send information to:

Linda Weaver
Orthopaedic Section, APTA, Inc.
2920 East Ave. South, Suite 200
La Crosse, WI 54601

Orthopaedic Section, APTA, Inc.
CSM Board of Directors Meeting
February 13, 1998
Boston, Massechussettes
Minutes
(3/5/98)

The CSM Board of Directors Meeting was called to order at the Marriott Hotel in Boston, Massachusetts at 8:00 AM on Friday, February 13, 1998 by President Bill Boissonnault.

ROLL CALL:
Present
Bill Boissonnault, President
Nancy White, Vice President
Dorothy Santi, Treasurer
Elaine Rosen, Director
Joe Farrell, Director
Lola Rosenbaum, Education Chair
Terri DeFlorian, Executive Director
Jonathan Cooperman, *OP* Editor
Catherine Patla, Nominating Committee Chair
William O'Grady, Specialty Council Chair
Helene Fearon, Practice Chair
Mari Bosworth, Public Relations Chair
Fran Welk, APTA Board Liaison
Susan Appling, Incoming OP Editor
Kim Dunleavy, Incoming Nominating Chair
Terry Randall, Incoming Public Relations Chair

Absent:
Steve McDavitt, Practice Chair
Dan Riddle, Research Chair

MEETING SUMMARY:

The minutes from the September 26-27, 1998 Fall Board of Directors meeting in Chicago, IL were approved by the Board as printed.

The agenda for the CSM Board of Directors meeting on February 13, 1998 was approved as printed.

MOTIONS

=MOTION 1=Recommendation that the home study course series be taken out of the Education Committee and put under Publications.**=TABLED=**

The Finance Committee was charged to look into a restructuring of the entire Section office to accommodate outside publications and home study courses on their spring conference call and bring forth a recommendation to the Board at their June 1998 meeting in Orlando.

=MOTION 2=Review and update the agreement to provide editorial services for the home study course editor.**=TABLED=**

The Executive Committee will meet to discuss changes to the current contract immediately following the Board meeting.

=MOTION 3=Increase the honorarium for the home study course authors from $750 per manuscript to $1,000 per manuscript. If two or more authors write a manuscript, they may divide the honorarium as they wish.**=PASSED=**

=MOTION 4=Reimburse home study course authors up to $250 for expenses incurred in preparing their manuscript. Receipts must be submitted with the reimbursement form at the time of the request.**=PASSED=**

=MOTION 5=The Section reserves the right to subtract $100 per week from a home study course author's honorarium for each week their manuscript is overdue.**=PASSED=**

=MOTION 6=The Home Study Course Editor to propose topics for home study courses suggested by membership to the Board for approval. The Board may suggest authors and the Editor will develop the final course description and finalize authors.**=PASSED=**

=MOTION 7=Provide an annual merit/cost of living increase for the home study course editor.**=TABLED=**

The Executive Committee will meet to discuss providing an annual merit/cost of living increase to the HSC editor immediately following the Board meeting.

=MOTION 8=Provide funding for the home study course editor to attend CSM and SME. The Fall Meeting will be funded on an "as needed basis" as decided by the President. The Section will reimburse travel and three days lodging/meals for each meeting according to the Section's reimbursement policy.**=PASSED=**

=MOTION 9=A home study course re-run will be any course initially offered in a previous year.**=PASSED=**

=MOTION 10= Rescind the 1992 motion which reads as follows: Recommend that the Section fund one new home study course per year and one re-run per year. Editor would be paid $500 for each re-run and each author would receive $100 per re-run.**=PASSED=**

=MOTION 11= A home study course is considered "retired" five years after its initial offering or in less than five years at the discretion of the HSC Editor, and when it is out of stock.= **PASSED=**

=MOTION 12= Produce a maximum of three home study courses per year and co-sponsor no more than one outside home study course per year. Co-sponsorships will be taken on a first come first serve basis with no more than one produced for the same group in a four year period. Profits (after expenses) will be split 50/50. The outside organization must provide topics, authors, and a subject matter expert.**=TABLED=**

The Finance Committee was charged to look at this during their spring conference call in relation to restructuring the Section office and report back to the Board in June 1998.

=MOTION 13= Produce a home study course on CD ROM.**=TABLED=**

Carolyn Wadsworth, HSC Editor and Sharon Klinski, Publishing Manager were charged to compile the information needed to pursue putting the Current Concepts course on CD ROM. They are to provide this information to outside companies for obtaining three different bids. Lola Rosenbaum will provide the content material and Dorothy Santi will review the financial information. A report will be brought back to the Board in June 1998.

=MOTION 14= Approve the Section office purchasing a new computer server. Estimated cost $4,500.**=PASSED=**

The money will be taken from the

Miscellaneous Fund.

=MOTION 15= Approve the Section office purchasing two new printers, one being a color printer. Estimated cost $2,000.**=PASSED=**

The money will be taken from the Miscellaneous Fund.

=MOTION 16= Eliminate sending a separate drop letter survey to members who have dropped the Section and replace this mailing with a one sheet flyer (produced in-house) promoting non-member subscriptions to *JOSPT* and *OP.* Questions asking why Section membership has been dropped will be included in the flyer.**=PASSED=**

The mailing will be done for one year and then re-evaluated.

=MOTION 17= Approve offering an off-site course on veterinary physical therapy in 1998. Money for this course is already budgeted under Education. **=PASSED=**

=MOTION 18= Approve offering a preconference course at CSM in 1999 on patellofemoral pain.**=PASSED=**

=MOTION 19= Approval to fund Susan Appling an honorarium, travel, and lodging/meals as a speaker for the Foot and Ankle course in November 1998.**=PASSED=**

=MOTION 20= Pursue offering CEUs for clinical articles in *OP* to Orthopaedic Section members at no cost. Offer one clinically based article per issue beginning with the September . 1998 issue.**=PASSED=**

Lola Rosenbaum to contact Paul Howard and have him work with Susan Appling on this.

=MOTION 21= Approve the Section accepting monetary sponsorship for CSM activities from product companies only, not providers. The Education Chair will get approval from the Board for each interested cosponsor.=PASSED=

=MOTION 22= Approve the following policy for speaker reimbursement. This policy will apply to special interest groups, round tables, and regular CSM programming:

Four or more hours of educational programming

PTs and Non-PTs (expenses reimbursed according to Section policy)
- CSM registration for day(s) presenting
- Lodging/meals for day(s) presenting
- Travel
- Honorarium ($100 per speaking hour)

One to three hours of educational programming

PTs
- Registration for day presenting
- Honorarium ($300 per speaking hour)

Non-PTs
- CSM registration for day(s) presenting
- Lodging/meals for day(s) presenting
- Travel
- Honorarium ($100 per speaking hour)

CSM Joint Programming
- Follow the above policy
- Must have a signed contract specifying the amount prior to CSM
- Programming counts as one half the time scheduled

Special Interest Groups (SIGs)
- Limited to the amount of programming dollars approved by their Board
- May program up to four hours presentations

Round Tables
- Can not exceed $1,000 in speaker expenses
- May program up to three hours of presentations

=PASSED=

=MOTION 23= Approve the following policy on home study course co-sponsorship with Section SIGs:

Orthopaedic Section SIGs wishing to apply for a HSC co-sponsorship will follow this protocol, the SIG will:

a select topics of interest.
b obtain Orthopaedic Section Board approval on the course topic.
c identify authors willing to write manuscripts. The authors must possess expertise in the identified content area and demonstrate writing experience.
d solicit interest and support from their members.

The Section will pay all costs of producing the course. Any profits above the costs will be split 50% to the SIG and 50% to the Section.**=PASSED=**

=MOTION 24= Approve the following policy on home study course co-sponsorship with non-Orthopaedic Section APTA groups:

Non-Orthopaedic Section groups wishing to apply for a HSC co-sponsorship will follow this protocol:

a Non-Orthopaedic Section group will select topics, authors, and an editor.
b Obtain Orthopaedic Section Board approval on the course topic.
c Identify authors willing to write manuscripts. The authors must possess expertise in the identified content area and demonstrate writing experience.
d Solicit interest and support from their members.

The Section will pay all costs of producing the course. Any profits above the costs will be split 80% to the outside group and 20% to the Section. **=TABLED=**

The Finance Committee was charged to look at this during their spring conference call and bring information back to the Board at their June meeting.

=MOTION 25= The Orthopaedic Section promotes having Section representation at outside meetings each year by purchasing exhibit booth space. The Public Relations Committee will gather information on dates, costs, and persons who could represent the Section at various conferences and report back to the Board in June.**=PASSED=**

=MOTION 26= The Board approves selling the remaining stock of DACPs to ABPTS at a cost of $3.10 each. ABPTS is to pay for shipping.**=PASSED=**

=MOTION 27= Approve $7,500 to fund a three day meeting for OHSIG Compendium formation: "Payor/Government Agencies Guide," "Employer Guide," and "Reimbursement/Regulatory Guide" to be convened in 1998.**=PASSED=**

=MOTION 28= Approve the "Job Description for Technical Writer/Assistant for Occupational Health Compendium". **=TABLED=**

OHSIG to contact APTA regarding this and report back to the Board at the June meeting.

=MOTION 29= Two percent of active Section membership is required to form a SIG.**=PASSED=**

Fiscal Implication: $5,000 (annual budget amount)

=MOTION 30= The Compendium on Manual Therapy be available to Section members only and that the Practice Committee be charged to develop an appropriate packet of materials for Chapter Legislative Chairs.**=PASSED=**

=MOTION 31= Subscribe to the *Journal of the American Chiropractic Association* and *Chiropractic Dynamics* and forward on to the Practice Committee Chairs for monitoring.**=PASSED=**

=MOTION 32= From the SIG template for creating bylaws Elaine Rosen and Tara Fredrickson will identify items that are mandatory from items that are to be used as guidelines to follow and present to the Board at their June meeting.**=PASSED=**

=MOTION 33= Approve the following plan for maintaining and adding to the Section's archives for the purpose of preserving the history of the Orthopaedic Section:

1) The "Guidelines for the APTA Component Archives" will be utilized as a framework for documenting the Sections history. Documentation will include minutes from meetings, bylaws, public relations materials, publications

from the beginning of the Sections history, home study courses, lists/photos of all Section Award recipients, and photos will be organized and stored at the Sections office.

2) Key individuals (Burkhart, Edgelow, Paris, Santi, Grove, etc.) who were in attendance at the initial Section "conception" meeting will be interviewed by Joe Farrell or appointed Section Historian during 1998. The interviews will be videotaped according to the APTA "Guide to Oral History."
3) The Board appointed Carolyn Wadsworth to author a detailed history of the Section which will be published in *Orthopaedic Practice* throughout the Section's 25th anniversary year (1999).
4) Store copies of all materials electronically, which would require scanning documents into a computer. Written documentation should also be maintained. Copies of all materials should be stored in a fireproof vault away from the Section office.
5) A Director on the Section's Board of Directors will be the official "Historian of the Orthopaedic Section."
6) Throughout the 25th Anniversary year (1999) historical items of the Section will be openly displayed at the Section office.
7) Deadline for completion of the Historical Documentation and Archiving of the Section's History should be no later than Combined Sections Meeting 1999, which will be the 25th Anniversary of the Section. **=PASSED=**

=MOTION 34= Approve a new policy on soliciting audit RFPs for the annual Section audit.**=TABLED=**

Policy to be approved at the June Board Meeting.

=MOTION 35= The Orthopaedic Section either develop a task force or submit a proposal to a professional organization (the Rand Corporation) to determine how much it would cost to have a meta analysis done on therapeutic exercise for orthopaedic conditions. A list of 8 to 10 diagnoses could be given that the Section deems important to include.**=TABLED=**

The Research Committee will work with Bill Boissonnault and contact the Rand Corporation and Andrew Guiccione at APTA to gather more information and report back to the Board in June.

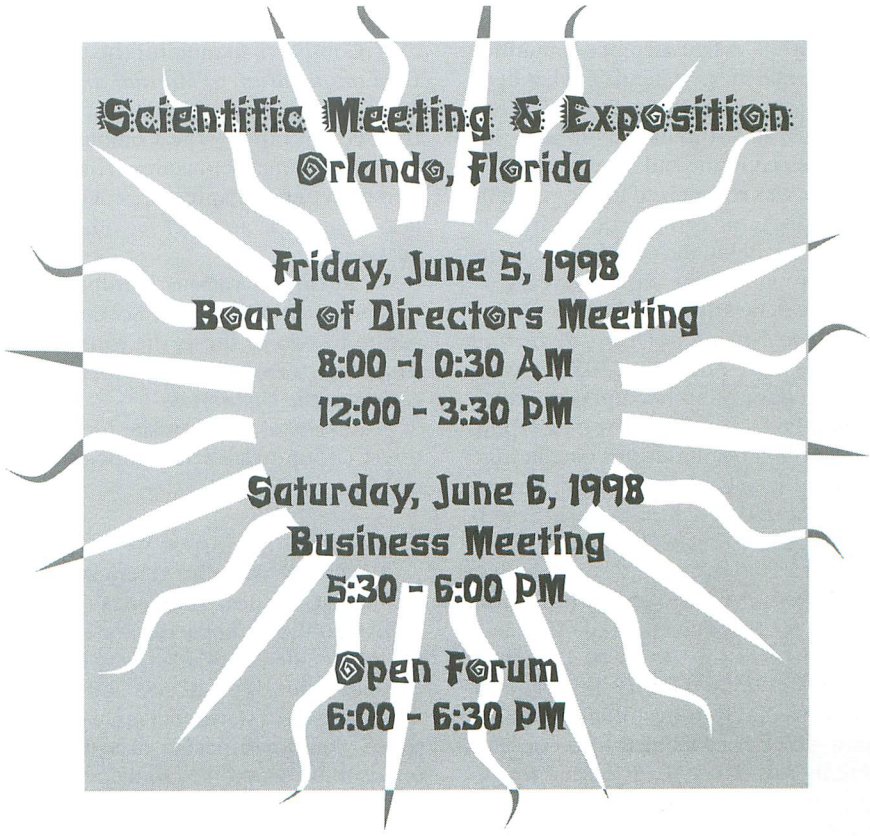
=MOTION 36= Approve printing an awards flyer each year for the CSM awards evening event.**=PASSED=**

=MOTION 37=

Committee Chairs and the Home Study Course Editor must bring activities before the Board when any of the following pertain:

1. There are fiscal implications.
2. The activity/decision affects policy.
3. The activity/decision affects the Section's bylaws.
4. Controversial issues affecting the public or physical therapy.
5. Involves quoting something on behalf of the Section.
6. Anything to be disseminated over the media spokesperson network.
7. A change in the responsibility of the committee.
8. Any additions or changes to committee members.

ADJOURNMENT



Orthopaedic Section, APTA, Inc. Business Meeting

COMBINED SECTIONS MEETING
BOSTON, MASSACHUSETTES
FEBRUARY 14, 1998
MINUTES

CALL TO ORDER AND WELCOME - President, Bill Boissonnault, MS, PT

Doris Gerace, Registered Parliamentarian, was the parliamentarian for the meeting.

BOARD OF DIRECTOR REPORTS

A. President - Bill Boissonnault, MS, PT

1. **=MOTION=** Approve the minutes from the business meeting at SME in San Diego, California on May 31, 1997 as printed in the Fall 1997 issue of *Orthopaedic Physical Therapy Practice*. **=PASSED=**

2. Business meeting will remain two hours in length. Recognition of all award winners, outgoing officers, and committee chairs will be conducted at the Awards Evening function on Saturday instead of during the business meeting. Handouts were provided highlighting certain items of committee reports.

3. The APTA Board of Directors agreed at their November 1997 meeting to implement a postprofessional clinical residency program credentialing process beginning January 1, 1998. A five member committee on clinical residency credentialing has been appointed to oversee the process. The five members are Mike Cibulka, Jay Irrgang, Joe Godges, Colleen Kigin, and Toby Long. Carol Jo Tichenor was recognized for her tremendous contribution to the process and Jan Richardson for being the one thread of consistency throughout the past four years.

4. 1998 will be known as the year of transition for *The Journal of Orthopaedic and Sports Physical Therapy* (*JOSPT*) with changes in editor, publisher, and editorial office. Allen Press, Inc. will be the new publisher. They will begin transitioning in June 1998 and officially take over as of January 1, 1999. The *JOSPT* Editor-in-Chief Search Committee, consisting of Dan Riddle, Chair; Nancy White; Dorothy Santi; George Davies; and Mark DeCarlo; interviewed the editor candidates at CSM. The editorial office will move from Iowa City, Iowa to LaCrosse, Wisconsin and housed on the first floor of the Orthopaedic Section's office building. The new office is scheduled to be up and running by July 1, 1998. A Journal transition plan has been mapped out by the current publisher, Williams & Wilkins; Editor-in-Chief, Dr. Gary Smidt; and Managing Editor, Debbie Durham.

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

1. Nancy White has been appointed to the Board of Trustees for *The Foundation for Physical Therapy*. Nancy was also involved in the *JOSPT* Editor-in-Chief Search Committee, and in the selection process for the new *JOSPT* publishing company. Nancy is also the Board liaison for the home study courses.

2. The *Award for Excellence in Teaching Orthopaedic Physical Therapy* was presented to Paul Howard, PhD, PT, Cert MDT. The *Outstanding Physical Therapy Student Award* was presented to Stacy Procopio from Slippery Rock University in Pennsylvania.

C. Treasurer - Dorothy Santi, PT

(See financial graphs in 1997 Annual Report) Dorothy Santi interviewed and hired a new investment firm to manage the Section's investments. The new firm is A. G. Edwards.

D. Director - Elaine Rosen, MS, PT, OCS

1. Continues to monitor the updating of the *Compendium of Manual and Manipulative Therapy* which is available through the Section office. The Compendium will be mailed annually to component executive personnel and chapter presidents. It will also be used as a model for other practice act issues.

2. Reviewed various chiropractic journals and newsletters. The Section will subscribe to two of these, the *Journal of the American Chiropractic Association* and *Chiropractic Dynamics*.

3. Reviewed the template for Special Interest Group bylaws and policies and procedures.

E. Director - Joe Farrell, MS, PT

1. Working with the American Academy of Manual Physical Therapists (AAOMPT), APTA, and the Orthopaedic Section Practice Committee on issues relating to trading manipulation for direct access and chiropractors going after states that are weak legislatively. Develop a packet of legislative materials to be sent to key individuals in each state designated as a legislative contact for that state.

2. Board liaison for the Specialty Council and Practice Committee.

3. Developed a plan and will oversee the development of the Section's archives and history.

COMMITTEE REPORTS

(See Section News for more information)

A. Education Committee - Lola Rosenbaum, PT, OCS

1. Recognized committee members and others who have been instrumental in helping out at CSM or on other projects throughout the past year.

2. The Section will not offer a Current Concepts course in 1998 but will look at offering it again in 1999. The Committee is looking into offering this course on CD ROM in the future.

3. A veterinarian physical therapy round table was offered for the first time at CSM. A physical therapist assistant round table will be offered for the first time at CSM 1999.

B. Research Committee - Dan Riddle, PhD, PT (Report given by Bill Boissonnault)

1. The Section has approved donating $100,000 to the Foundation for Physical Therapy in 1998 for research grants. Of this, $20,000 will be unrestricted money to cover the administration costs associated with this research grant program and $80,000 is to be used to fund research relating to efficacy/effectiveness of orthopaedic physical therapy intervention for orthopaedic conditions.

2. The new Research Committee Chair will be Phil McClure.

C. Orthopaedic Physical Therapy Practice - Jonathan Cooperman, MS, PT, JD

The new Editor for *Orthopaedic Physical Therapy Practice* will be Susan Appling.

D. Specialty Council - Bill O'Grady, MS, PT, OCS, MTC

Joe Godges steps down as a committee member in June 1998 and Bill O'Grady rotates off as chair of the council in June. The new chair will be Jean Bryan. The ABPTS is taking recommendations for a council member. The selection will be made in April 1998. New appointments take over July 1, 1998.

E. Public Relations - Mari Bosworth, PT

The new Public Relations Committee Chair will be Terry Randall.

F. JOSPT - Gary Smidt, Editor-in-Chief
(See 1997 Annual Report)

G. Nominating Committee - Catherine Patla, MMSc, PT, OCS

1. All members who were slated to run for office in the past election were thanked. The Nominating Committee members were also recognized.

The 1998 election results are:
Bill Boissonnault, President
Nancy White, Vice President
Mary Ann Wilmarth, Nominating Committee Member
Number of ballots cast: 1,334
Number of invalid ballots: -0-
Number of valid ballots: 1,334

2.There was a call from the floor for recommendations for the next election that will include one Director, Treasurer, and Nominating Committee Member. No nominations were taken.

H. Special Interest Groups (SIG)/Round Tables

Presidents of the Occupational Health, Foot and Ankle, Performing Arts, and Pain Management SIGs were recognized as well as the representatives from the Veterinary Physical Therapy Roundtable.

OLD/NEW BUSINESS

A. **=MOTION=** The Performing Arts SIG charges the APTA Board of Directors to investigate and pursue to the maximum extent possible the development of an Institutional Review Board to facilitate the development of clinical research in physical therapy and report back to the House of Delegates in 1999.

Rationale: It has come to our attention that many practicing clinicians do not have access to an Institutional Review Board (IRB) through which to gain approval for clinical studies. Commercial IRBs do exist but are prohibitively expensive. This provides a substantial barrier to the development of clinical research. It would be ideal to team independent clinicians with faculty from nearby institutions. It is not reasonable, however, to expect that universities can absorb the additional responsibility of reviewing research protocols of "unaffiliated" clinicians in addition to their own studies and those of their students.

=AMENDED MOTION= The Orthopaedic Section charges the Research Committee with investigating the procedures necessary for development of Institutional Review Boards for those clinicians who do not have access to one. Report back to the Section membership in February 1999. **=PASSED=**

SECTION/PRACTICE ISSUES FORUM
- Vice President, Nancy White, MS, PT, OCS

A. Following are the recommended changes to the Section's goals and objectives:

GOAL #3
Objectives:

1. Support clinical research that validates the outcome *and cost* effectiveness and *cost* efficacy of orthopaedic physical therapy.

Strategies:

1. Investigate methods of IRBs

3. Identify and promote members with orthopaedic physical therapy research expertise to organizations external to the Section.

Strategies:

1. Investigate the Rand Corporation for use in a meta analysis study

GOAL #5

Actively strive to promote orthopaedic physical therapy presence in the legislative arenas and to protect orthopaedic physical therapy practice.

The objectives under this goal are passive not active. The goal suggests a more active part be taken in legislative activity.

B. It was recommended that a formal call go out to all members asking for contributions of photographs for the Section's archives.

Adjournment - 10:00 AM

Section News

Directors Report

This year I have concentrated on the professional relationship between the AAOMPT/Orthopaedic Section, Practice issues, devised a method of monitoring the history of the Orthopaedic Section, and continued communication as the Board Liaison with the Practice committee and Orthopaedic Specialty Council.

In December, 1997 I received a copy of a letter from Mike Rogers, President of the AAOMPT which is requesting that the APTA establish an official "External Liaison" relationship with the AAOMPT. This relationship will further strengthen the Sections and APTA's relationship with the AAOMPT.

As the Board will learn via the Practice committees report, issues relating to negotiating physical therapy practice rights away, such as, manipulation for "Direct Access" on the state level and revisiting the role of the physical therapy assistant within our profession, are in the forefront of concern for the Section and the APTA.

Joe Farrell, MS, PT
Director

Home Study Course Editor

There continues to be a significant demand for the Orthopaedic Section Home Study Courses. Registrations for the three courses we produced in 1997 averaged 662.

We are in the process of producing three full-length (six manuscripts) courses in 1998: *Occupational Health, Strength & Conditioning,* and *Pharmacology.* I hope that they will prove to be as popular as previous courses.

Tom Vastano, President of North American Seminars, and I have been discussing the possibility of producing a course on CD-ROM. He has just completed a CD-ROM of Jenny McConnell's course, and has access to the latest software technology. We met with Tom at CSM to view samples of his work and discuss the logistics of creating such a major project.

Sharon, LaVerne, and Sheila have proven remarkably adept at managing the many stages of the publication process. Our manuscripts are rolling off the presses on schedule, with impressive new designs and enticing layouts. The staff also stays abreast of correspondence with the authors and registrants, grade tests, and account for the continuing education credits we award.

Carolyn Wadsworth, MS, PT, OCS, CHT
Editor, Home Study Course Series

Education Program Committee Report

CSM Program

Each Orthopaedic Section Special Interest Group (SIG) and Roundtable has an education chair who assists in program planning for Orthopaedic Section members. In addition to this group, we also receive assistance from Education Program Committee members. The Orthopaedic Section programming is extensive and offers many choices for our members attending CSM. Since this may present a conflict for someone trying to attend two lectures scheduled concurrently, we also offer audiotapes of the programs supplemented with handouts from each speaker. Thanks to the following people for contributing to the planning of a successful program: Susan Appling, Marshall Hagins, Ellen Hamilton, Laurie Kenny, Joe Kleinkort, Lin McGonagle, Gwen Parrott, Donavon Reimche, Steve Reischl, Gary Shankman, Kim Schoensee, Tom Watson, and Linda Weaver.

PTA Activities

In an effort to increase membership benefits and meet the needs of Orthopaedic Section physical therapist assistants, Gary Shankman, PTA was appointed to the Education/Program Committee. Gary assisted in planning the first Section programming specifically dedicated to PTAs. He also is being utilized in addressing the needs of PTAs participating in our home study courses. The Section will sponsor an Orthopaedic PTA Roundtable at the Seattle CSM in 1999 but, there will be a meeting of orthopaedic PTAs at the Boston CSM. This group will assist in planning future programming, proposing criteria for an Orthopaedic Section PTA Award, and proposing an education track for PTAs wishing to specialize in orthopaedics. A special thank you to Gary Shankman, Ellen Hamilton, and Paul Howard for their work on this.

Home Study Courses

Home study courses (HSC) provide an excellent means of keeping pace with current orthopaedic physical therapy practice and obtaining continuing education units. The Section has offered several courses this year and cosponsored a course with the Affiliate Assembly. Carolyn Wadsworth and Sharon Klinski have been instrumental in the successful production of our HSCs this year. In an effort to utilize computer mediums and in conjunction with the American Academy of Orthopaedic Surgeons, we offered a home study course on the knee on CD-ROM. We will continue to investigate the computer as an alternate means of presenting continuing education.

Orthopaedic Specialty Certification Services and Advanced Review Course

We updated the OCS study guide this year and in addition to references, included suggestions on preparing for the exam from members who have recently taken the exam. This guide is available at no charge to Section members. We offered the advanced review course twice this year and were forced to cancel one of the courses when only four registrations were received. We have not scheduled the advanced review course for 1998 and are currently looking at other methods of providing an advanced review of orthopaedics. Look for more on this in the future. Thanks to Tara Fredrickson for her assistance in updating the study guide. The Section will also be participating with other Sections of the APTA in offering CSM programming specifically designed to serve the needs of certified specialists.

Other Educational Programming

In conjunction with the National Institutes of Health, we plan to offer a foot and ankle course in November 1998. We are also planning an introductory veterinary physical therapy course. Further information on these courses will be forthcoming in *JOSPT* and *OP*. We encourage our Special Interest Groups, Roundtables, and other institutions to cosponsor courses with us.

Lola Rosenbaum, PT, OCS
Chair, Education Committee

Research Committee

The Research Committee completed their review of articles for the Rose Excellence in Research Award for 1997. This year's winner is Dr. Diane Jette for a paper published in the September 1996 issue of *Physical Therapy*. The paper is entitled "Physical Therapy and Health Outcomes in Patients with Spinal Impairments" Dr. Jette presented her research at the Black Tie and Roses at CSM.

The Research Committee received a total of 49 Poster abstracts and 62 Platform abstracts for CSM '98. These numbers are approximately 40% higher than the number of poster and platform presentations at the 1997 CSM meeting. Interest in presenting orthopaedic research at CSM is consistently growing. Paul Beattie, Kelly Fitzgerald, Mike Wooden, and Jonathan Cooperman assisted in chairing the sessions.

The committee reviewed a total of 14 grants submitted for the Clinical Research Grant Program. The grants are now in review with the External Grant Review Committee. The Research Committee is very pleased and excited with the number and quality of the submitted grants.

Daniel L. Riddle, PhD, PT
Chair, Research Committee

Orthopaedic Specialty Council

1997 was a very busy year. Many exciting activities occurred throughout the year. 1998 promises to be a good year also. Below is a summary of activities during the past year and some the events and activities slated for this year:

1. 1997 Specialty examination: In 1997, 148 candidates passed the OCS examination. 215 first time candidates took the exam while there were 71 persons who retook the exam.

2. Long Range Strategic Planning- The council participated in the long-range strategic planning conference for the Orthopaedic Section in Chicago this fall. Jean Bryan represented the council at this meeting. The section supported the mechanism to sit for the certification exam. More details of this meeting will be published in *Orthopaedic Practice*.

3. National Board of Medical Examiners: The specialty council, Mike Cibulka, PT, OCS; Nancy Henderson, PhD, PT, OCS; and Anne Porter-Hoke, PT, OCS participated in the item review and exam construction in August at NBME. The quality and service of the staff at NBME was first rate. We look forward to working with them in the future.

4. Item writer's workshop CSM: We had a very successful SACE workshop. We had both first time item writers and experienced item writers in attendance. As a result we were able to add several new questions to our test item bank. Those in attendance were quite impressed with the process and the amount of work that goes into writing the questions. Our current group of item writers is:

Susan Appling, PT, OCS
Anne Campbell, PT, OCS
Hillary Greenberger, MS, PT, OCS
Bob Johnson, MS, PT, OCS
Douglas Kelsey, PhD PT, OCS
Robert Landel DPT, PT, OCS
Robert Leighton, PT, OCS
Donald Olsen EdD, PT, OCS
Mindy Oxman-Turner, MS, PT
Ronna Semonian, PT, OCS
A. Russell Smith, Jr. MMSc, PT, OCS
Linda Steiner, MS, PT, OCS
Deborah Stetts, MPT, OCS
Michael Tollan, PT, OCS
John Tomberlin, PT, OCS
Mark Trimble, PT, OCS
Tom Watson, MEd, PT

The three members of the committee of content experts are:

Brenda Green, MMSc, PT, OCS
Nancy Henderson, PhD, PT, OCS
Alan Lee MS, PT, OCS.

5. Certification/Recertification forum: The inaugural forum on certification and recertification took place at CSM 97. It was highly attended by persons interested in orthopaedics. In fact, that we will have our own room at CSM 98. We continue to try to serve our section members through these type venues.

6. Candidates for the 98 OCS Examination: As of this date we have a total of 336 candidates qualified to sit for the 1998 OCS examination. This represents a 17.5% increase over last year. First time takers increased by 25% while the number of retakers remained fairly constant.

7. Re-certification Candidates: The first group of re-certification candidates has applied for re-certification for 1998. There have 11 candidates thus far. The numbers will increase in the coming years.

8. Residency Pathway to OCS: The APTA will begin credentialing residency programs in the near future. The Orthopaedic Specialty Council has proposed that a graduate of a credentialed Orthopaedic Residency program be immediately eligible to sit for the OCS exam. This proposal is currently being reviewed by the ABPTS. Approval is pending. This would allow two options to meet the minimum eligibility to sit for the examination: 1) the current 5 year (10,000 hours) requirement, and 2) successful completion of a credentialed.

9. Executive Director of the APTA Specialist Certification Department- With the departure of Christine Niero from this position so quickly, we were quite fortunate to have Eileen Walsh come back to us. She really has a lot of history and institutional knowledge that will continue to make our job easier. She will only be an interim director. However, it should help buy time for the selection of our new executive director.

10. CSM 98- We will be putting on a separate certification/re-certification forum. With better organization and space, we are looking forward to even better attendance. The SACE workshop will also be held on February 11, 1998 during the day prior to opening ceremonies.

11. Marketing: Marketing specialization is very important to the future of specialization. In the early years of specialization the values were more intrinsic. The spring meeting of ABPTS had a combined forum with council members from all specialties and ABPTS board members. Each group had a facilitator. The general conclusion was that for specialization to have value it requires both intrinsic (self-fulfillment) values and extrinsic (economic) value. The council has attended the American Academy of Family Practitioners in New Orleans in 1996 and had OCS representatives in Chicago in 1997. We are entertaining going to the American Academy of Orthopaedic Surgeon meeting in March. We feel that the greater exposure we have with physicians and payers, the more meaningful the specialization process will be.

12. ABPTS Streamlining: At our fall ABPTS meeting we agreed to meet in Alexandria in the fall. We felt that we could be just as efficient communicating with our board representative and each other via E-mail, FAX, or telephone.

13. Quadrennial Test Validation: On April 30, 1998 the council will meet with NBME in Philadelphia to perform the quadrennial test validation process. Because of the large bank of questions and other factors, we are fortunate to only have to do this once every 4 years instead of yearly like the other specialties. If all goes as planned 13 people will participate in this. Funding issues may change these numbers.

14. Changes in the Council for 1998: In June, Joe Godges will be stepping down from his position on the board. He has down a wonderful job on the board. He is organized, levelheaded, and has a lot

of institutional knowledge. His calm presence and sage advice will be sorely missed. Jean Bryan will assume the duty as the specialty council chair as I step down in June. My tenure on the board will end next year. Selection for a new member to replace Joe has already begun.

15. SIGs: We will continue to work closely with the SIGs in order to promote them and encourage them to develop descriptions of their practice and subspecialty recognition process.

William H. O'Grady, MA, PT, OCS, COMT, FAAPM
Chair, Orthopaedic Specialty Council

Practice Committee Report

In November the AAOMPT Practice Affairs Committee reported their membership expressed concern about two areas related to chiropractic infringement on PT practice.

1. ***Trading manipulation for direct access*** (States like AR, WA, SD and others) possibly due to intimidation or not knowing how to or who could or should defend it.

2. The observation nationally of cases reported where ***Chiropractic momentum is being directed at picking on weak legislative state practice fronts in PT in order to remove manual therapy from PT practice and retain "exclusive" ownership.***

AAOMPT Practice Affairs Committee presented their goal: *Prevent giving up manipulative PT practice or any other practice component in PT for legislative gains or otherwise.*

As a start AAOMPT has developed and completed a directory of members from their Practice Affairs Committee willing to work with the Orthopaedic Section Practice Committee in completing steps toward completion of that goal.

From the above the *Orthopaedic Practice Committee* has initiated and developed the following ongoing plan.

Orthopaedic Practice Committee recommendations and strategies:

1. Provide an orthopaedic liaison/representative for every state to provide support and monitoring for any related PT practice issue especially as it relates to orthopaedics/OMT.
2. Provide every state with an information packet that provides the effective defense of manipulation scope of practice in PT in a concise manner including information to utilize with legislators and the public.
3. Establish a communication interrelationship / coordination with the Orthopaedic Practice Committee and related Executive, AAOMPT, APTA Department of Health Policy, State Chapters and APTA Sections for use addressing any PT practice affairs concern.

Since the AAOMPT Denver meeting in October, I have drafted a cover letter and handout with information addressing all of the above. The outline includes definitions of manual therapy, manipulation/mobilization in PT, support of manipulation in PT since the beginning, the entire Chiropractic report supporting Manipulation in PT, PT Practice acts addressing manipulation, Wilk's case, and references from the Chiropractic task force.

I have discussed this information as well as a proposed communication model with Bill Boissonault MS, PT, and Jerry Connolly PT, Senior VP of APTA Health Policy Division. We plan to discuss finalizing this plan during in the near future. My goal was to have this strategy in place before CSM with all participants informed and activated.

Due to recently developed additional information available from Helene Fearon and my inability to arrange a coordinated meeting with Bill Boissonault and Jerry Connolly, March is a more realistic date. Helene and I will follow up with this and a report along with Practice Committee membership, goals, and strategies following CSM.

Stephen Mc Davitt PT, MS
Co-Chair Practice Committee

Public Relations Committee Report

1. Student Guest Program

This year's winner is Heather Smith from Indiana University Physical Therapy Program in Indianapolis.

2. Sponsor -a- Student Program

A total of sixty-four students have been matched with an Orthopaedic Section member willing to pay their one year membership ($15) in the Orthopaedic Section. We currently have 139 students interested in sponsorship and 5 unmatched sponsors. Students who received sponsorship through this program were sent a survey.

3. Media Spokesperson Network (MSN)

The Media Spokesperson Network (MSN) has not been utilized since the Fall Board Meeting. The MSN now has commitments from 124 Orthopaedic Section members in 76 of the top 100 media markets in the United States. We have sent out letters of invitation to an additional 48 individuals and are awaiting a response from them. I will attempt phone contact with these individuals prior to CSM '98. We are in need of spokespersons in the following media markets:

Charlotte, NC
Greenville, SC & Asheville, NC
West Palm Beach, FL
Albany-Schenectady-Troy, NY
Charleston-Huntington, WV
Fresno-Visalia, CA
Tulsa, OK
Flint, MI
Wichita-Hutchinson, KS
Green Bay-Appleton, WI
Omaha, NE
Springfield-Decatur, IL
Springfield, MO
South Bend, IN
Fort Myers - Naples, FL
Huntsville, AL
Johnstown-Altoona, PA
Burlington, VT & Plattsburgh, NY
Youngstown, OH
Evansville, IN
Colorado Springs, CO
Waco, TX
Lincoln, NE

4. Orthopaedic Clinical Specialist (OCS) Marketing Project

Michael Tollan, PR Committee member, is in the process of completing work on this project.

5. Strategic Planning

Initial strategies were outlined to correspond with goals that were set by the Orthopaedic Section Board and Committee Chairs at the Fall Board Meeting. These were submitted to the Section office. The further development and refinement of these strategies is ongoing.

6. Public Relations Committee

According to standard practice, the present Public Relations Committee will dissolve concurrent with my resignation. Letters thanking committee members for their service will be mailed following the Combined Sections Meeting. I have thoroughly enjoyed the opportunity to serve as the Public Relations Chair for the past three years. They have been a challenging and rewarding three years. The Board, Committee Chairs and Orthopaedic Section staff are truly some of the finest individuals our profession has to offer. My sincere thanks to all the Orthopaedic Section staff for the hard work and assistance you have provided to me during my term. My sincere thanks to Bill Boissonnault and the Board and Committee Chairs, for mentoring and encour-

aging me.

Mari Bosworth, PT
Chair, Public Relations Committee

Nominating Committee Report

Following is the Nominating Committee's Report on the 1998 election for the positions of President, Vice President and Nominating Committee member for the Orthopaedic Section, APTA, Inc.

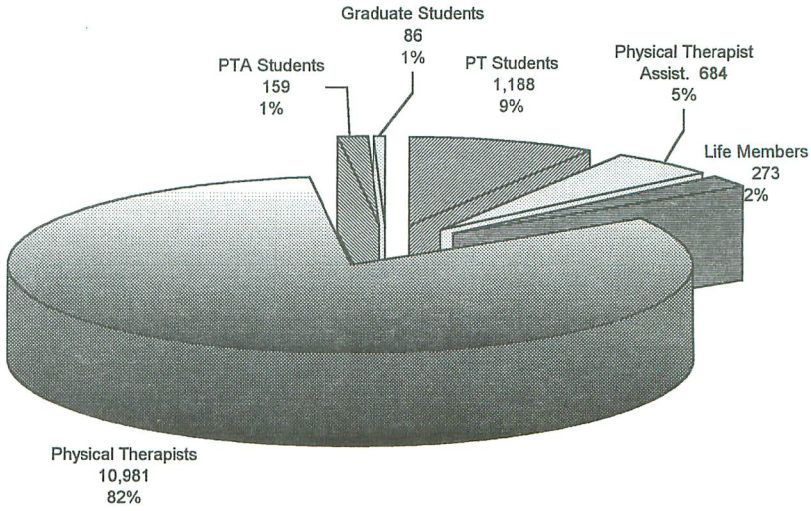
Number of ballots cast:	1,334
Number of invalid ballots:	0
Number of valid ballots:	1,334

Serving for a second term as President is Bill Boissonnault and Vice President is Nancy White. The newly elected Nominating committee Member is Mary Ann Wilmarth.

Catherine Patla, PT
Chair, Nominating Committee

Membership Report

Orthopaedic Section Membership Breakdown As of December 31, 1997



Request for Recommendations for Orthopaedic Section Offices

The Orthopaedic Section of the APTA needs your input for qualified candidates to run for the offices listed below. If you would like the opportunity to serve the Section or know of qualified members who would serve, please fill in the requested information. Return this completed form to the Section office by September 1, 1998. The Nominating Committee will solicit the consent to run and biographical information from the person you recommend

_____
(Print Full Name of Recommended Nominee)

_____
Address

_____
City, State, Zip

_____
(Area Code) Home Phone Number

_____
(Area Code) Office Phone Number

is recommended as a nominee for election to the position of:

CHECK THE APPROPRIATE POSITION:

☐ DIRECTOR (3 yr. term)
Takes on responsibilities and duties and acts as liaison to various committees as designated by the President.

☐ TREASURER (3 yr. term)
Should have good working knowledge of accrual accounting, annual and long range budgeting, reserve funds and investment strategies. Nominees shall have served on the Finance Committee for no less than one year from the time they would assume the office of Treasurer.

☐ NOMINATING COMMITTEE MEMBER (3 yr. Term; 2 yrs. as member, 1 yr. as Chair) Should have broad exposure to membership to assist in formation of the slate of officers.

Nominator: _____

Address: _____

Phone: _____

PLEASE RETURN BY SEPTEMBER 1, 1998 TO:
Tara Fredrickson
Orthopaedic Section, APTA
2920 East Avenue South, Suite 200
La Crosse, WI 54601

REQUEST FOR PROPOSALS
ORTHOPAEDIC SECTION, APTA

CLINICAL RESEARCH GRANT PROGRAM

Purpose: The Orthopaedic Section must support its members by funding studies designed to systematically examine orthopaedic practice issues. The purpose of this grant program is to address the urgent need for clinical research in orthopaedic physical therapy.

Targeted Recipients of the Grant Program: The grant program is designed to provide funding for any Orthopaedic Section member who has the clinical resources to examine a well-defined practice issue, but who needs some external funding to facilitate the completion of a clinical research project.

Studies Eligible for Funding: The four types of studies that will qualify for funding are studies that: *1)* examine the effectiveness of a treatment approach on a well-defined sample of patients with orthopaedic problems; *2)* examine patient classification procedures for purposes of determining an appropriate treatment; *3)* further establish the meaningfulness of an examination procedure or a series of examination procedures used by orthopaedic physical therapists; and *4)* examine the role of the orthopaedic physical therapist in the health care environment. Authors must stipulate which purpose their grant is designed to address.

Categories of Funding: Funding will be divided into two categories:

Type I Grant Funding: $1,000.00 maximum

This program is designed for therapists who require only a small amount of funding for a project or are in the process of developing a project. The funds in this program will be used for pilot data collection, equipment, and consultation.

Type II Grant Funding: $5,000.00 maximum

This program is designed for therapists who are ready to begin a project but need additional resources. The grant may be used to purchase equipment, pay consultation fees, recruit patients, or fund clinicians. Clinicians receiving funding from this program will be expected to present their results at CSM within 3 years of receiving funding. Recipients will receive $300 to allay costs associated with presenting at CSM.

Criteria for Funding: Type I Grant

—A specific and well-defined purpose that is judged to be consistent with the four types of studies eligible for funding and described above

—The sample studied must include patients. For studies examining the role of the orthopaedic physical therapist in the health care environment, the sample studied would be therapists involved in the delivery of care

—Priority given to projects designed to include multiple clinical sites

—Priority given to studies examining treatment effectiveness

—Institutional Review Board approval from participating site(s) and letter of support from facility(ies) participating in the study

—Principal investigator must be an Orthopaedic Section member

—Priority given to projects that are currently not receiving funding

—The funding period will be 1 year

Criteria for Funding: Type II Grant

Criteria are the same as listed above for the Type I grant plus the following:

—Evidence of some pilot work

—The funding period will be 1 year, renewable for up to 3 years, if judged to be appropriate

Determination of the Award: Deadline for submission of grant proposals is **December 1, 1998.** Each application should include one original and six copies of all material. The Grant Review Committee will review and evaluate each eligible application. A total of $30,000 is budgeted for grants each year (five at $1,000 and five at $5,000). All applicants will be notified of the results by **March 1, 1999.**

To receive an application, call or write to:

Clinical Research Grant Program
Orthopaedic Section, APTA, Inc.
2920 East Avenue South
La Crosse, WI 54601
800/444-3982

CHECK OUT SOME OF THE AWARDS OFFERED BY THE ORTHOPAEDIC SECTION!

Listed below are descriptions of various awards offered by the Orthopaedic Section, APTA, Inc. Please contact the Orthopaedic Section office if you would like a detailed description of each award and the criteria for submission.

AWARD FOR EXCELLENCE IN TEACHING OF ORTHOPAEDIC PHYSICAL THERAPY

Submission deadline: November 1, 1998

This award is given to recognize and support excellence in instructing OPT principles and techniques through the acknowledgment of an individual with exemplary teaching skills. The instructor nominated for this award must devote the majority of his/her professional career to student education, serving as a mentor and role model with evidence of strong student rapport. The instructor's instructional techniques must be intellectually challenging and promote necessary knowledge and skills.

OUTSTANDING PT & PTA STUDENT AWARD

Submission deadline: November 1, 1998

The purpose of this award is to identify a student physical therapist and a student physical therapist assistant (first professional degree) with exceptional scholastic ability and potential for contribution to orthopaedic physical therapy. The eligible student shall excel in academic performance in both the professional and pre-requisite phases of their educational program, and be involved in professional organizations and activities that provide the potential growth and contributions to the profession and orthopaedic physical therapy.

PARIS DISTINGUISHED SERVICE AWARD

Submission deadline: August 1, 1998

This award is given to acknowledge and honor a most outstanding Orthopaedic Section member whose contributions to the Section are of exceptional and enduring value. The nominee shall have made substantial contributions to the Section in areas such as: professional recognition and respect for the Section's achievements, and advanced public awareness of orthopaedic physical therapy.

JAMES A. GOULD RESEARCH AWARD

Submission deadline: September 15, 1998

This award is given to acknowledge and honor authors of outstanding clinical research investigations which make significant contributions to orthopaedic physical therapy, and to contribute to the quality of research in orthopaedic physical therapy. The submitted paper must be original, unpublished, and cannot be currently under review ofconsideration for publication in any journal.

ROSE EXCELLENCE IN RESEARCH AWARD

Submission deadline: September 1, 1998

The purpose of this award is to recognize and reward a physical therapist who has made a significant contribution to the literature dealing with the science, theory, or practice of orthopaedic physical therapy. The submitted article must be a report of research but may deal with basic sciences, applied science, or clinical research.

Contact the Orthopaedic Section office for more information pertaining to the above mentioned awards, as well as the other benefits and services offered to Orthopaedic Section members!

Orthopaedic Section, APTA, Inc.
2920 East Avenue South
La Crosse, WI 54601
800/444-3982 * 608/788-3965 (fax)
orthostaff@centuryinter.net

Orthopaedic Physical Therapy Home Study Course 98-A

Strength & Conditioning Applications in Orthopaedics

April - September 1998

Proposed Topics and Authors

- **Plyometrics-Specific Applications in Orthopaedics**
  Donald A. Chu, PhD, PT, ATC, CSCS and
  Douglas J. Cordier, MS, PT, ATC, CSCS
- **Flexibility - Principles of Soft Tissue Extensibility & Joint Contracture Management**
  Gordon Cummings, MA, PT and *Carol Reynolds,* PT
- **Concepts of Muscle Training**
  Mark Albert, MEd, PT, SCS, ATC
- **Cardiopulmonary Considerations in Orthopaedic Physical Therapy**
  Scott Irwin, MA, PT
- **Proprioception, Balance and Coordination**
  William Inverso, Jr., PT
- **Open & Closed Kinetic Chain Exercise - Functional Applications in Orthopaedics**
  Jeff G. Konin, MEd, ATC, MPT

Editor

Carolyn Wadsworth, MS, PT, OCS, CHT - Editor
Gary Shankman, OPA-C, PTA, ATC, PTA - Editorial Consultant

Additional Questions

Orthopaedic Section, APTA, 1-800-444-3982 x 213

Registration Fees

Register by Feb. 6, 1998
Limited supply available after this date.

$150 Orthopaedic Section Members

$225 APTA Members

$300 Non-APTA Members

Special discounted rates are available for institutions with multiple registrants. Please call the Section office for complete information.

*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.

Educational Credit

30 contact hours

A certificate of completion will be awarded to participants after successfully completing the final test. Only the registrant named will obtain the CEUs. No exceptions will be made. ATC approved.

Objective: The objective of the Orthopaedic Section Home Study Course is to provide a self-paced learning experience on issues relating to assessment, treatment and research as these topics apply to the patient with musculoskeletal problems.

Registration Form

Orthopaedic Physical Therapy Home Study Course 98-A

Name _____

Mailing Address _____

City _____ State _____ Zip _____

Daytime Telephone No.(_____) _____ APTA# _____

For clarity, enclose a business card.

Please make check payable to: **Orthopaedic Section, APTA**

Fax registration & Visa or MasterCard number to:

608-788-3965

Please check:

☐ Orthopaedic Section Member

☐ APTA Member

☐ Non-APTA Member

☐ I wish to become an Orthopaedic Section Member ($50) or Affiliate Member ($30) and take advantage of the member rate.

(Wisconsin Residents add 5.5% Sales Tax)

Visa/MC (circle one)# _____ **Exp.** _____

Signature _____

Mail Check and registration to: **Orthopaedic Section, APTA**, 2920 East Avenue South, La Crosse, WI 54601

Occupational Health Physical Therapists Special Interest Group

Orthopaedic Section, APTA, Inc.

Spring 1998 Volume 5, Number 1

President's Letter

In one sense, it seems like only yesterday that I performed my first functional capacity evaluation and worked with my first return to work patient. Upon reflection, I'm forced to realize this happened back in 1985. Over the past 13 years, I consider myself fortunate to have been involved in the early phases of industrial rehabilitation. This experience enabled me to advance my career initially into occupational health and now as a full-time ergonomics consultant. I know I share a similar experience with quite a few other physical therapists.

Whether working with worker's compensation patients, safety managers, occupational health nurses, or production managers, I have come to truly appreciate the role that physical therapists play in helping people return to work as well as the whole area of injury prevention.

One of my on-going challenges is to maintain my effectiveness and remain enthusiastic about the kind work I do. I'm sure that we all do this in any number of ways based on our own practice situations and personalities. One of the ways I have discovered is discussing pertinent issues with my colleagues. For me, one of the great meeting grounds for this interaction takes place in my work as an officer in the Occupational Health Physical Therapy Special Interest Group (OHPTSIG).

At present, the OHPTSIG is the largest SIG in the Orthopaedic Section at close to 400 members. Members of the SIG have been actively involved in a number of projects since the SIG's formation in 1992. As with any SIG, the intent is to provide a means of communication and sharing among people with mutual interests. As a result, the SIG has been extensively involved in promoting dialogue and developing guidelines related to the occupational health community.

One such effort has been in the development of an occupational health compendium. Work on the compendium to date includes: Definition of Occupational Health Physical Therapy, Guidelines for Physical Therapy Management of the Acutely Injured Worker, Guidelines/Standards for FCE and Work Conditioning/Hardening Guidelines. In 1998 with joint funding from the APTA, Orthopaedic Section Board of Directors, and the OHPTSIG, work will continue on the compendium. Guidelines for Prevention and Education, Payor/Government Agencies Guide, Employer Guide, Reimbursement Regulatory Guide, Guidelines for Ergonomics, and Legal and Risk Management Guidelines will be drafted and reviewed.

The OHPTSIG was instrumental in bringing several educational offerings to the 1998 Combined Sections Meeting in Boston. The Hot Topics Forum included Status on Ergonomic Regulatory and Certification Issues and Diversifying your Industrial Physical Therapy Practice. It was a pleasure to see the rooms filled with an enthusiastic audience with tangible information sharing.

Working with the Orthopaedic Section staff, the SIG coordinated a six-topic occupational health home study course for 1998. The first two topics, the Science of Ergonomics and Consulting have been released. The remaining four topics will be released on a monthly basis. Please contact the Section office if you're interested in more information about obtaining the home study course.

At the beginning of 1998 a membership survey was sent to all members of the OHPTSIG. Results of the survey are being collated and will be distributed to the membership. We are very interested in determining the interest and needs of our members. We continue to be very excited about the realized and yet to be realized potential occupational health poses for our profession. For many of us, we have entered into an entirely different realm of practice; one that is continually stimulating and challenging. Speaking for all the members of the OHPTSIG Executive Board we encourage your comments and participation in the SIG.

I would like to publicly thank all of the Executive Board for their excellent initiative in this past year. We look forward to serving the membership in 1998 and beyond.

Mark A. Anderson, MA, PT, CPE
President, OHPTSIG

CONTENTS

Guidelines For Publication Of The OHPTSIG Newsletter

Instructions To Authors

1. The OHPTSIG Newsletter will be published quarterly (four times per year) within *Orthopaedic Physical Therapy Practice* (OPTP). The following are editorial deadlines for publication year 1998:

ISSUE DATE	INTERNAL DEADLINE	EXTERNAL DEADLINE
Newsletter/OPTP	Date Materials Due to OHPTSIG Sec.	Date Materials Due to Section Office
Spring (April 1998)	February 20, 1998	February 13, 1998
Summer (September 1998)	July 24, 1998	July 17, 1998
Fall (November 1998)	September 18, 1998	September 11, 1998
Winter (January 1999)	November 20, 1998	November 13, 1998

2. OHPTSIG will publish articles, news updates, interviews, announcements, abstracts, and briefs related to the subjects of Occupational Health and Physical Therapy/Rehabilitation, Safety/Injury Prevention. Research results are not appropriate for this publication. Case studies are appropriate.

3. Two (2) original copies (FAX REPRODUCTIONS ARE UNACCEPTABLE) of each item presented for publication shall be submitted to the OHPTSIG Secretary Newsletter Editor to be received NO LATER THAN the internal deadline (see above). Each item should be forwarded to:

Roberta L. Kayser, PT
6400 Dutchman's Parkway, Suite 20
Phone: (502)897-0100
Fax: (502)897-0042
E-Mail: bkayser@juno.com

4. Each submission must be double spaced, with a one-inch margin at each side. In lieu of submitting two originals, the author MAY submit a diskette containing the item saved either as Word for Windows Document or as an ASCII file. If the modem method of submission is desired by the author, special arrangements should be made with the OHPTSIG Secretary/Newsletter Editor.

5. Abstracts are considered brief synopses of recent articles related to the current practice of occupational health physical therapy. Abstractors may not abstract any article to which they were in any way recognized as an author or contributor. The OHPTSIG Newsletter Editor has the final OHPTSIG responsibility for decisions regarding content, quality, and recommendations for publication of abstracts. The OPTP editor has the final authority regarding publication.

6. Upon receipt of the items, the OHPTSIG Editor and representatives of the OHPTSIG's Publication Committee, will review each item for:

- Appropriateness/Relationship to Current OHPTSIG Objectives
- Readability
- Reliability and/or Verification of Information
- Relevance

The editor reserves the right to make all final decisions concerning text revisions or modifications prior to publication.

Roberta L. Kayser, PT
OHPTSIG Secretary and Publications Committee Chair

Ohptsig Board Members Listing

President
Mark Anderson, MA, PT, CPE
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Nominating Committee Chair
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ph: (360) 455-0260
fax: (360) 456-3482

Advisory Group on Ergonomics
Mark Anderson, PT
(See President)

Secretary's Corner

As our OHPTSIG moves ahead in addressing the many issues that affect physical therapists practicing in both occupational health and ergonomic settings, we ask each of you for input, information, and assistance. The following are ways you can participate in our OHPTSIG:

1. Contact any Executive Board member directly to voice opinions and make suggestions (see listing of Board members).
2. Submit articles, news updates, interviews, practice profiles, etc. that relate to some aspect of occupational health physical therapy for this quarterly OHPTSIG newsletter publication.
3. Say "YES" when the Nominating Committee members contact you to run for office.
4. Volunteer to chair or be a member of a committee. If you have volunteered via membership survey or verbally, and haven't been contacted, call Mark Anderson, PT, OHPTSIG President at (612) 401-9296.
5. Participate and reply promptly in each field review process for draft documents. If you are not receiving documents for review, contact the Orthopaedic Section Office to update our mailing list.

The OHPTSIG Executive Board thanks all of you for your participation in facilitating improved communication and professional sharing within the field of occupational health physical therapy.

Economics Of Ergonomics

Employers can reduce worker's compensation costs and injuries while boosting morale and productivity through simple ergonomics programs, the General Accounting Office (GAO) said in a report, "Work Protection: Private Sector Ergonomics Yield Positive Results," released August 27, 1997.

Congress' auditing arm, the GAO, found that worker's compensation costs for musculoskeletal disorders dropped 36 to 91% as the five companies included in the study put ergonomics programs into practice. For example, compensation costs decreased by about 80% between 1992 and 1996. AMP Inc., Navistar International Transportation Corp., Sisters of Charity Health System, and Texas Instruments were also included in the study.

To obtain a single copy of the 140-page report free of charge, send your request to:

US General Accounting Office
PO Box 37050
Washington, DC 20013
Phone: (202)512-6000
Fax: (202) 512-6061

This report can also be viewed and/or downloaded from the GAO website at: http:/www.gao.gov

Ergonomics And Quality Deficiencies

Many companies use the principles of ergonomics to help control problems of the musculoskeletal system that can lead to cumulative trauma disorders. Improving quality in the workplace is an equally important use of ergonomics.

A recent issue of APPLIED ERGONOMICS addressed just this issue. Experienced auto assembly plant workers identified their most demanding tasks, those parts most difficult to assemble, and those that were most psychologically demanding.

Information on quality deficiencies was then obtained from the internal quality statistics of the company and from interviews with quality control personnel.

The result showed that quality deficiencies were three times as common for the work tasks with ergonomics problems when compared with other tasks. Controlling ergonomics problems has a direct impact on improving quality.

Applied Ergonomics. 1995;26(1):15-20.

Submitted by Mark Anderson, MS, PT, CPE
OHPTSIG President

Most Back Pain Is Acute But Not Related To A Workplace Injury

To describe the prevalence of subtypes of low back pain, investigators gathered data from a group model HMO with a population of 54,000. Trained physical therapists assessed subtypes in all patients referred for low back pain over a 9-month period. Of the 213 patients evaluated for low back pain, 72% had acute pain (3 months), and only 15% had work-related injury. After classification into subtypes, 32% had acute low back strain, 28% had radicular syndromes, 14% had chronic back strain, 10% had sacroiliac syndromes, 6% had posterior facet syndrome, and the remaining 10% included 12 different syndromes. Only about 10% had more than one clinical syndrome. Attention to subtypes may provide a way to improve primary care management of low back pain.

Journal of Family Practice. 1997;45:331-335.

by Mark Kerestan, PT

CORRECTION

In a previous OHPTSIG Newsletter, the telephone number for NIOSH was printed incorrectly. The correct telephone number is:

1-800-35NIOSH
1-800-356-4674

We apologize for any inconvenience that may have resulted from this inadvertent error.

O'NET Update

As you may or may not know, there has been a movement underway by the Department of Labor (DOL) to phase out the D.O.T and replace it over the next several years with O'NET. Although many had hoped that there would someday be improvements in the D.O.T., O'NET does not appear to be that improvement. Instead of providing increased objectivity and specificity in work classification, the O'NET system appears to be more vague, very general, and developed utilizing inappropriate terminology.

In the course of O'NET's development, the DOL sought

absolutely no input from the rehabilitation community. Physical therapists and vocational evaluators who have reviewed the system agree that the O'NET work classification system will be of little or no value to those professionals who quantify and classify functional abilities of persons with impairments and disabilities.

Recently, the contract for O'NET development has changed hands. It has been moved from the American Institute for Research (AIR) to the Research Triangle Institute (RTI). With this contract change, we may see our final opportunity to provide information which impacts the O'NET product. Research Triangle Institute may be more receptive to change. The APTA, AOTA, and vocational evaluator's association need to make a combined effort to contact the DOL and RTI to communicate O'NET's shortcomings. If we don't pull together to make our position known, we may ultimately be stuck with a work classification system that is substandard, unusable, or not legally defensible. The alternative may be returning to the use of an outdated D.O.T., which will not be updated or revised.

This issue was discussed in detail at the OHPTSIG business meeting. The prototype document can be accessed for review by writing for a copy or going to the O'NET website:

Utah Department of Employment Security
c/o Utah Occupational Field Analysis
PO Box 45249
Salt Lake City, Utah 84145-9249
O'NET Website
http:/www.doleta.gov/programs/onet

Only after reviewing the O'NET document thoroughly, the membership of the OHPTSIG is encouraged to write or call the following organizations to make them aware of our concerns and input with regard to O'NET:

Department of Labor
Social Security Administration
Research Triangle Institute
Your Senators and Congressional Representatives

For more O'NET information, please contact Deborah Lechner, PT, MS, OHPTSIG Vice President at (205)595-4536.

Speaker's Bureau

The OHPTSIG has developed a dynamic speaker's bureau of professionals with expertise in the area of occupational health, consulting, and ergonomics. If you, or someone you know, have expertise they wish to share and would like to be included in our speaker data base, we would like to know the following information:

Name _____
Company _____
Business Address _____
Day Phone / Evening Phone _____
E-mail Address _____
Area(s) of expertise Topic Headings _____

Please submit this information to:
Jenn Panageas, MSPT
Med-Data Systems, Inc.
2091 Springdale Road Suite 16
Cherry Hill, NJ 08003
ph: (609) 751-8080
fax: (609)751-8885
e-mail: jpan@injersey.com

FOOT & ANKLE

SPECIAL INTEREST GROUP
ORTHOPAEDIC SECTION, APTA, INC.

MINUTES OF THE FOOT AND ANKLE SPECIAL INTEREST GROUP (FASIG) MEETING
BOSTON, MA
FEBRUARY 14, 1998

The meeting was called to order by Steve Baitch at 12:35 p.m. There were 16 individuals in attendance.

MOTION:

It was moved and seconded to approve the minutes of the February 14, 1997 meeting in Dallas, TX. Passed by unanimous vote.

OFFICER/COMMITTEE REPORTS:

Chair: Steve Baitch reported that there has been a change in the way that the Orthopaedic Section determines if a Special Interest Group (SIG) will continue from one year to the next. A list of 200 or more signatures of individuals expressing interest in the SIG will no longer be required except for those SIGs who are just forming. If the goals of a SIG are being met on an annual basis, no further documentation will be required. It was anticipated that attendance at SIG programming will be a key factor in determining solvency.

Steve also led a discussion about ways to increase exposure of the FASIG to Orthopaedic Section members in general. One popular idea was a short, clinical description of the presentations from the programming at CSM published in *Orthopaedic Physical Therapy Practice* (*OPTP*). These presentations would be spread out over the course of the year until the next CSM.

The progress of establishing a relationship with the American Orthopaedic Foot and Ankle Society (AOFAS) was characterized as ongoing, but slow.

Motion:

It was moved by Tom McPoil and seconded by Steve Baitch that "the Chair of the FASIG proceed with the development of a collaborative relationship with the AOFAS by specifically working on the following objectives:

- Appoint Steve Baitch (as Chair of the FASIG) to be the Liaison to the AOFAS for the remaining term of his office.
- Exchange attendance of liaisons at the annual national meetings, waiving registration fees.
- Exchange educational exhibits at the annual national meetings, to acquaint respective members of the goals of the two groups.

Passed unanimously.

Vice-Chair: Steve Reischl reviewed the Orthopaedic Section's new policy for equalizing speaker fees across all SIGs. The policy is basically a $300.00 honorarium plus registration fees for the day of the presentation.

Secretary/Treasurer: Mark Cornwall reported that expenditures for 1997 were $3198.82. This is 31.5% below budget. The budget for next year will continue at the same level of $4670.00, most of which is travel for officers to CSM and speaker fees and honorariums.

Research: Irene McClay reported on a previous survey conducted of the membership regarding their interest in research internships. A list of those willing to host an internship was distributed to those present. She also reported that money is available from the Orthopaedic Section for clinical research. Ways to facilitate the use of these funds for a wide variety of uses was discussed. Irene indicated that she will include information and more details about research internships and clinical research opportunities in the next *OPTP*. There continues to be interest in holding a Foot and Ankle Research Retreat. Possible sites and objectives were discussed. Debbie Nawoczenski volunteered to host the first one in the "Wine" country of New York.

Practice: Joe Tamaro reported on the progress made in developing common terminology for the foot and ankle. Based on the comments obtained in the open forum on the subject yesterday, Joe will revise the terminology document and see that it is published in the *OPTP* within the next 6 months.

Old Business: There was no old business to take care of.

Elections: Elections were conducted for the office of Vice Chair and Nominating Committee. The following individuals were elected:

Vice Chair: Mark W. Cornwall

Nominating Committee: Nancy Henderson

Because Mark Cornwall has not completed his current term as Secretary/Treasurer, Steve Baitch appointed Tom McPoil to serve in that capacity until the next meeting where elections will be held.

New Business:

Moved: It was moved by Mark Cornwall and seconded by Michael Wooden that "the FASIG of the Orthopaedic Section of the APTA survey the entire Orthopaedic Section membership regarding their interest

and extent of involvement in conservative care of the foot and ankle." This survey will be developed in consultation with the Practice Committee of the FASIG and report its results at the next business meeting in Seattle, WA.

Passed unanimously.

With no further business, the meeting was adjourned at 1:40 p.m.

Respectfully submitted by Mark Cornwall
Secretary/Treasurer, FASIG

CHAIR REPORT
CSM 1998

If the attendance at the FASIG educational meeting is any indication of the growing interest in the area of Foot and Ankle, then the most suitable location for our meeting may be the King Dome in Seattle, for CSM in 1998. The numbers of participants at FASIGs educational meeting were surpassed only by the degree of excellence demonstrated by our presenters. A standing room only crowd of over 100 participants had the privilege of listening to excellent presentations given by Dr. Judy Baumhauer, Debbie Nawoczenski, Mike O'Donnell, and Jim Zachazewski.

The minutes of the business report were submitted by Mark Cornwall and the minutes of the Dallas meeting 1997 were passed unanimously. Outgoing Chair, Steve Reischl, and nominating committee member, Walt Jenkins were recognized for their outstanding efforts over the past two years, in their respective positions. As newly elected chairman, I can now fully appreciate the amount of work and responsibility that coincides with these positions. Many thanks.

New elections were held with following results:

Vice Chair - Mark Cornwall

Interim Secretary/Treasurer - Tom McPoil

Nominating Committee - Nancy Henderson

Congratulations to all our newly appointed committee members. I am looking forward to working with you in the near future.

Other issues of the business meeting included Steve Reischl's report on the Orthopaedic Section's new policy for speaker's fee being equaled at $300.00 honorarium plus registration fees for the day of presentation. Irene McClay, Chair of the Research Committee, reported that money is available from the Orthopaedic Section for clinical internships and clinical research opportunities in the next *OPTP*. There continues to be an interest in holding a Foot and Ankle research retreat. Debbie Nawozenski volunteered to host the first one in the "Wine" country of New York.

Joe Tomaro, Chair of the Practice Act committee led an intense discussion on terminology issues relating to the area of foot and ankle. He also has committed to publishing the results of this terminology document in *OPTP* within the next months. I'm sure that the publication of these results will stimulate much further debate regarding these terminology issues.

One of the major concerns prior to CSM was the problem of low membership for FASIG as well as other special interest groups over the past year. Of greatest concern was the fact that at least 200 members were necessary to maintain a SIG status. However, my fears were laid to rest when Dorothy Santi informed the FASIG Board that only an initial membership of 200 was needed to form a SIG and that the members could still drop below 200, allowing the SIG to function independently. It should also be noted that FASIGs numbers have grown from 118 to approximately 200 members, thanks to the diligent work of our committee members and the Orthopaedic Section. Mark Cornwall also suggested that FASIG conduct a survey of the entire Orthopaedic Section of the APTA, regarding the extent of involvement in conservative care of the foot and ankle. This survey will be coordinated with the Practice Committee and the Orthopaedic Section and present its results in Seattle, next year at CSM.

In order to encourage further participation of other Orthopaedic Section members it was suggested that the lecturers of the educational FASIG meeting would submit a short description of their presentation to *OPTP*. These presentations would be spread out over the course of the year, prior to the next CSM.

I also had the pleasure of meeting with Dr. Judy Baumhauer, acting liaison of the American Foot and Ankle Society, for the purpose of developing a collaborative relationship between AOFAS and FASIG. The Committee agreed to pursue the following objectives in an attempt to further communicate between these two groups.

1. Appoint Steve Baitch to be the liaison to the AOFAS for the remaining term of his office as Chair of FASIG.

2. Exchange attendance of liaisons at the annual national meetings, waiving registration fees.

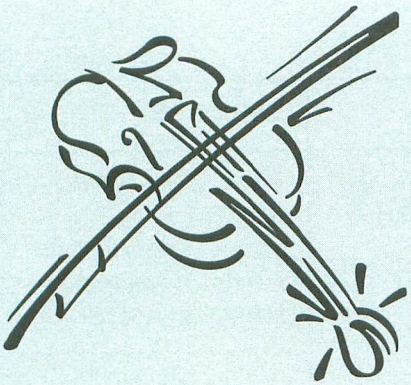
3. Exchange education exhibits at the annual national meetings to acquaint respective members of the goals of the two groups.

I also intend to seek the endorsement of the Orthopedic Section Board for the purpose of promoting growth between our two groups.

Overall, I found this year's CSM in Boston to be an extremely positive one, which easily exceeded my expectations. This could not have been accomplished without the diligent efforts of our committee and quest for knowledge from our participants. I would also like to thank Susan Appling and Dorothy Santi for their input during our Business meeting, as well as assistance from Tara Fredrickson, Lola Rosenbaum, and Sharon Klinski, throughout the year.

Remember, if you are not yet a member of FASIG, we encourage you to join. If you are already a member of the Orthopaedic Section, keep in mind that there is no need to "show us the money," just sign up to be a member of FASIG. I look forward to the opportunity to meet with you in Seattle in 1999.

With Regards,
Stephen P. Baitch, PT
Chairman, FASIG



Performing Arts

SPECIAL INTEREST GROUP **ORTHOPAEDIC SECTION, APTA, INC.**

Dear PASIG members:

We've just returned from an exciting and productive CSM 1998 for the PASIG. Our membership numbers leaped upward, and lots of energy and enthusiasm will be productively harnessed toward future goals. The election results were announced at CSM: Nick Quarrier was elected for Vice President and Shaw Bronner was re-elected for Secretary. We are including new PASIG five-year objectives and the minutes from our annual business meeting. Two new task force committees were formed, one within the PR/ Membership Committee and one within the Practice Committee.

The Media Liaison-Brochure Development Task Force, within the PR/Membership Committee, will be chaired by Jeff Stenback. Goals include development of logos, articles, brochures, and forming media contacts. This task force will also work closely with the Orthopaedic Section and APTA to utilize their existing media structures.

The Mentorship Task Force, within the Practice Committee, will be chaired by Donna Ritter. Initial goals are to ascertain existing and promote new entry-level PT student performing arts affiliations. We will then have a central clearinghouse for this information. Long range goals are to work toward developing standards of practice and specialization.

The Practice Committee delivered a Glossary of Performing Arts Terminology to the PASIG members at CSM. If you would like to obtain one, contact Tara Fredrickson at the Orthopaedic Section office. In preparation for an updated PASIG Membership Directory, you will be receiving a questionnaire. Please respond! We hope that this directory will become a resource for performing artists and other related practitioners. We need to know more about our members to achieve this goal. We will also be using this questionnaire to learn about existing performing arts student affiliations. We need your cooperation! For more information, contact Practice Chair, Shaw Bronner or Mentorship Chair, Donna Ritter.

The Research Committee is seeking a minimum of 3 performing arts single subject experimental design studies for presentation at CSM 1999 in Seattle. If you are interested, contact Research Chair, Jennifer Gamboa.

We appeal to those of you not able to come to the Boston CSM to get involved. Join one of our committees and help us grow. You can contact the Chairs of the Standing Committees or Task Force Chairs, call one of the Executive Board members, or go through Tara Fredrickson at the Orthopaedic Section Office. This is an exciting time for us, and although there is a lot of hard work, we have fun and learn at the same time.

Sincerely,
Shaw Bronner PT, MHS, OCS
Secretary, PASIG

Physical Therapy '98

APTA Scientific
Meeting & Exposition

PASIG Executive Board

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Treasurer: Jennifer Gamboa PT phone: (703) 528-3980 fax: (703) 528-3980 e-mail: jennS26@AOL.com

Secretary: Shaw Bronner, PT, MHS, OCS phone: (202) 752-4021 fax: (212) 752-4029 e-mail: sbronner@liu.edu

PASIG OBJECTIVES
Annual Business Meeting CSM 1998

Committee	1 Year	3 Year	5 Year
Education/ Programming (Standing) Chair: Nick Ouarrier	•Present discussion of Mentorship Program •Develop programs to provide continued support toward PASIG clinical research	•Develop joint programming with Manual Physical Therapy Group •Develop educational programs for community outreach and performing arts development	•Develop educational programs to fulfill standards established by the practice committee for performing arts specialists
ByLaws(Standing) Chair: Enid Woodward	•Bring Bylaw and Mission revisions to the members for vote		
Practice (Standing) Chair: Shaw Bronner Task Force Mentorship Chair: Donna Ritter	•Revise PASIG Directory •Develop central clearinghouse information for entry-level student mentorship •Collaborate with Orthopaedic Section Task Force on Clinical Residencies	•Investigate models for advanced clinical mentorship, residency, and fellowship •Establish practice guidelines for performing arts specialists	•Implement advanced mentorship programs and performing arts specialty guidelines as decided by the PASIG
Nominating (3 yrs) (Standing) Chair: Marika Molnar Comm: Donna Ritter & Carla Williams Comm Need: elect 1 person	•Organize nomination and election of President and Treasurer for 1999		
Research (Special) Chair: Jennifer Gamboa	•Promote development of APTA-sponsored IRB •Re-evaluate survey regarding areas of need for research •Support development of 3 single subject experimental design studies for CSM 98	•Consider implementation of multi-site epidemiological studies •Consider development of "writer's workshop" to facilitate manuscript preparation	•Promote and support the public presentation of clinical research 3 to 5 times per year
PR/Membership (Special) Chair: Brent Anderson Task Force Media Liaison/ Brochure Development: Jeff Stenback 1 Year	•Develop press kit and promote PR •Develop PASIG logo and brochure for PR and education to the public •Work with Orthopaedic Section to promote SIG PR •Achieve membership growth rate of 5%	•Develop national recognition of the PASIG	•Develop international recognition of the PASIG

PERFORMING ARTS SIG
Orthopaedic Section, APTA
Combined Sections Meeting, Boston, MA
2/14/98 Annual Business Meeting 12:30 p.m.

1. Call to order and Welcome: President, Brent Anderson
2. 1997 Treasurer's Report was delivered by Treasurer, Jennifer Gamboa.
3. 1997 Annual PASIG Business Meeting Minutes, were made available to the members before the meeting. They were accepted as printed.
4. Executive Committee Report was presented by Brent Anderson. Old business concerning the need to elect a new Nominating Committee member for a three year term was presented. Carla Williams was nominated from the floor and elected. The Chairs of Standing and Special Committees were asked to report.
5. Education Committee: Chair Marshall Hagins. Proposals for programming at CSM 1999 include:
   a) Joint programming with Occupational Health SIG (4 hours) with topics such as: the Industrial Medicine Model as a marketing model for performing arts, psychosocial aspects of performance, and ergonomic interventions.
   b) A Roundtable discussion on Mentorship and Specialization.
   c) Presentation of 3 single subject case studies, to follow up this year's research topic program.
6. Bylaws Committee: Chair Enid Woodward. Representative and committee member, Donna Ritter reported on the proposed changes to the bylaws which will be put to vote by the PASIG members, following approval by the Orthopaedic Section.
7. Practice Committee: Chair Shaw Bronner. Last year's goal of a Glossary of performing arts terminology was distributed to the membership. Current goals of the practice committee are to develop mentorship programs. STG: to develop a national list of PT student affiliation sites in performing arts. LTG: to investigate advanced specialization and residency criteria. A request for a volunteer Task Force Chair on Mentorship was made. STG: a revised and updated Membership Directory to be available by CSM 1999.
8. Nominating Committee: Chair Marika Molnar. Representative Brent Anderson reported on the election results. The new Vice President is Nick Quarrier. Secretary Shaw Bronner was re-elected.

Special Committees:

9. Research Committee: Chair Jennifer Gamboa. As a result of this year's CSM programming, a solicitation was made for 3 single subject experimental design studies to be presented at next year's CSM. As another outcome of the Research Committee's programming, Orthopaedic Section support for APTA sponsorship of an in-house IRB was solicited at the Orthopaedic Section Business Meeting. The proposal went to committee for further study. The support of other Sections is also being solicited. The survey of research needs had a reply of only 13/200, mostly dance. Another survey will be conducted this year to attempt improved participation.
10. PR/Membership Committee: Chair Brent Anderson. The success of increasing our membership through our programming at CSM was reported. New photos of the PASIG were obtained for the Orthopaedic Section booth. A request for a volunteer Task Force Chair for Brochure Development was made. Funds are available for brochure and logo development, and the Orthopaedic Section and APTA also have mechanisms in place to assist us. A request for a volunteer for Task Force Chair Media Liaison was also made. This person will work with existing channels at the Orthopaedic Section and APTA to develop a press kit, as well as develop new avenues to promote PASIG PR. Future goals to develop increased national and international recognition were reviewed. These include development of the multidisciplinary "Team Approach" in organizations such as IADMS and PAMA. "Dance UK" has approached us for collaboration. A request was made to help develop student PT awareness of the PASIG.
11. Website Committee: Chair Nick Quarrier. Reported that SIG websites have been taken over by the Orthopaedic Section. Reorganization has been slow. Our membership form is still available on the Web.
12. Unfinished Business: None.
13. New Business: Nick Quarrier, new VP, suggested we initiate a confirmation process for new PASIG members. Bob Turner brought to our attention that the PASIG Website cannot be accessed from the APTA Website.
    Nancy Byl proposed the PASIG devise ways for the PASIG Directory to become better known. Nick Quarrier suggested the use of stickers or logos with visual impact for the PASIG to become better known. Bruce Brownstein volunteered to download artwork in the public domain, which may be used for logo or sticker. Nancy Byl suggested pins might be an inexpensive way to implement this. She volunteered to look into contacts for pin manufacturing companies by March 13. The meeting was adjourned at 1:30 p.m.

PASIG Secretary, Shaw Bronner PT, MHS, OCS

A note from the new media liaison for the performing arts special interest group (PASIG):

We're looking for ideas! And we may be looking for you!

Anyone who has an interesting performing arts patient to use as a case study, ideas for discussion among PASIG members, an unusual or interesting treatment option, or an exciting happening related to their management of/interaction with performing artists should contact Jeff Stenback, PT, OCS by phone (305) 595-9425 or by fax (305) 595-8492. The PASIG would like to share your ideas/happenings with other PASIG members. Get involved in your special interest group and make 1998 an exciting year for PT and the arts!

Pain MANAGEMENT

SPECIAL INTEREST GROUP • ORTHOPAEDIC SECTION, APTA, INC.

Pain Management SIG, Orthopaedic Section, APTA Meeting
Boston, MA
February 14, 1998

Tom Watson, President, called the meeting to order at 12:33 p.m.

Present: 11 members.

Observing: Bill Boissonnault, President of the Orthopaedic Section of the APTA

Old Business:

A. Board certification versus specialization recognition was again discussed. Harriett Wittink felt that a physical therapist specialization should be pursued. The Orthopaedic Section would be supportive for resources if a proposal was submitted.

B. The SIG objectives were discussed and the methods for reaching these objectives. Maureen Simmonds suggested a core group of members of the SIG to meet informally to discuss strategies to meet the objectives. Maureen volunteered to be chairperson of the core group. Joe Kleinkort suggested a precursory informal meeting of the core group prior to the business meeting next year.

Our objective is to bring pain treatment strategies to the physical therapy community as well as the Orthopaedic Section. John Garzione will contact the other sections to see if they would be interested in sending a liaison to the pain SIG and if they would be interested in a multi-section program in pain treatment.

C. Lisa Cohen, 138 Albemarle Rd., Newton, MA 02173, e-mail: cohen.lisa@mgk.harvard.edu, will serve as editor of the newsletter. The newsletter will contain information on upcoming pain meetings, etc.

New Business:

A. Recruitment of new pain SIG members. Bill Boissonnault suggested advertising for pain SIG members in other section newsletters. A discussion was held regarding changing the bylaws to allow any section member to hold office not just members of the Orthopaedic Section. Bill Boissonnault will inquire as to if this is an Orthopaedic Section or APTA bylaw.

B. The Vice President is to be elected this year (even years). Joe Kleinkort was nominated by John Garzione and seconded by Harriett Wittink. There were no other nominations and Joe was elected unanimously.

C. A nominating committee will be developed as next year the positions of president and secretary will be up for election.

D. Next Year's Program Topic Ideas are:

1. The New Paradigm of Pain with Patrick Wall
2. Mitochondrial Pain
3. Reflex Sympathetic Dystropy
4. Chronic Fatigue Syndrome
5. Myofascial Pain/Fibromyalgia
6. Treatment Strategies for Neuropathic Pain.
7. Exercises for Chronic Endurance Deficits
8. Difficult Behavior of Patients with Pain

E. Tom encouraged members to write articles for the newsletter, *OPTP*, and *JOSPT*, including literature reviews, case studies, research studies, diagnosis, and assessment techniques.

F. Maureen Simmonds summarized her research on pain in the academic arena. 68% response with approximately 4 hours of pain management taught mostly in modalities courses.

The meeting was adjourned at 1:30 p.m.

John E. Garzione
Secretary

Veterinary

SPECIAL INTEREST GROUP

Orthopaedic Section, APTA, Inc.

Veterinary Physical Therapy Special Interest Group CSM Update

On behalf of the proposed Special Interest Group I would like to recognize everyone who helped to make our first course at CSM a success! Thank you to the Orthopaedic Section who supported this developing field of practice. Thank you to the Section staff who coordinated our mailing list, distributed newsletters, and held our hand through the process of proposing a SIG. Thank you to Lola Rosenbaum who guided our schedules and made it possible for us to present at Boston. Thank you to all the speakers and attendees who shared their enthusiasm for helping animals.

February 14th was a very busy day! We started with the Orthopaedic Section Business Meeting. We submitted information on Veterinary Physical Therapy to the Board including positive aspects and concerns for practice. Later, we met with Lola to begin planning for next year. After lunch we had our first informational meeting. As we initiated the process of organizing we were provided with overwhelming support and thoughtful feedback. Within a half hour we ventured into our course entitled "Veterinary Physical Therapy: How to Get Started." Many attendees stated that this was the highlight of the conference! Our panel of presenters included Lin McGonagle, MSPT, BS-Animal Science; Jane Avery, PT, CVT; David Levine, PhD, PT; Leslie Kerfoot, PT and President of CHAP; Dr. Geoffrey Clark, DVM; Julie Nettifee Osborn, BS, RVMT; and Debra Rudnick Ellis, PT, NCS. The course was intended as an introduction to the field of animal physical therapy and to briefly offer a variety of clinical applications based on physical therapists, veterinarians, and veterinary technicians perspectives. We learned that there is significant interest in continued programming in this area and that we need to request a larger room and more handouts. Our apologies to everyone who could not find a seat.

This coming year we hope to schedule a two-day preconference on Canine Sports Medicine at CSM 1999 which will include basic anatomy and physiology. Dr. Geoffrey Clark, DVM has already agreed to join us in Seattle. We are also in the process of coordinating with Cornell University College of Veterinary Medicine and the Canadian Horse and Animal Physiotherapy Association (CHAP) to invite Amanda Sutton, PT (Britain) to present on Physiotherapy for Equine Athletes. Amanda is an active member of the Association of Chartered Physiotherapists in Animal Therapy (ACPAT) and treated the British Olympic horses and Equestrian Team. This "Horse Course" is tentatively scheduled for the summer depending on Amanda's availability. It will most likely be offered on the East Coast in the U.S. and the West Coast in Canada. More details will be included in the next newsletter. We will present a shorter version of our introductory course on Veterinary Physical Therapy again at CSM with updates on legal and practice issues and current research. We will also be contacting book and product vendors so that there will be access to veterinary publications and equipment relating to veterinary physical therapy at upcoming conferences.

Our five year plan includes extended courses on Anatomy and Physiology of the dog, cat, horse, and wildlife. We will explore the possibility of having live demonstrations and dissection labs. We discussed the need to develop Home Study Courses for Anatomy/Physiology and Pharmacology. Future programming at CSM will include Safety and Handling, Treatment Protocols, Modalities, Hydrotherapy, Saddle Fitting, Biomechanics, Gait Analysis, Pathology/Dysfunction, and Behavior. We discussed the possibility of cosponsoring programs with the Aquatics, Neurology, Geriatrics, and Oncology Sections. Please contact the Orthopaedic Section with your ideas for programming and speakers so that we can add them to our plans.

We are developing a Veterinary Physical Therapy Resource Manual that will include an updated bibliography, internet contacts, veterinary and physical therapy textbooks, veterinary and veterinary technician colleges, animal organizations, products, and equipment. There will be a small "donation" involved depending on the printing costs. If you would like to contribute to the manual please contact the Section office April 1, 1998. We hope to have this manual available by June. We have also been asked to provide a glossary of animal related and equipment terms and a directory of members.

Several options were brought to our attention that we will forward to the Section Board for input:

1. The formation of an International and North American Alliance for Animal Physical Therapy.
2. Inclusion of Therapy Assistance Animals and Therapeutic Horseback Riding as part of the Veterinary Physical Therapy SIG.

3. Policy to allow veterinarians, veterinary technicians, and non-Orthopaedic section members to access PT Network, resources, and courses at a reasonable cost.

The most exciting news I have to share is that we were able to generate support from over 40 section members, which means that we now have enough signatures to become an official SIG! The approval by the Orthopaedic Section Board will occur at the Annual Conference in Orlando. Come join the celebration party during our first "business meeting." Thank you to all whom supported the SIG and provided input in organizing our unique group!

Submitted by Lin McGonagle, MSPT
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Phone: (315) 497-0333
Fax: (315) 497-1461
e-mail: lin@envisagel.com

THE SPECIALTY SECTIONS
of the
AMERICAN PHYSICAL THERAPY ASSOCIATION
Hereby Offer This

CALL FOR PARTICIPANTS

MULTISECTION PLATFORM AND POSTER PRESENTATIONS

APTA COMBINED SECTIONS MEETING

Seattle, Washington

FEBRUARY 3 - 7, 1999

Persons wishing to make platform or poster presentations of
RESEARCH, SPECIAL INTEREST, CASE STUDIES, OR THEORY
are invited to submit abstracts for consideration.

ALL SECTIONS ARE USING A COMMON SUBMISSION DATE AND FORMAT FOR CSM ABSTRACTS.

DEADLINE FOR RECEIPT OF ABSTRACTS IS TUESDAY, JULY 14, 1998.

Call 800-444-3982 and we will fax you complete details.

Orthopaedic Section, APTA, Inc
Annual Report 1997

SECTION PREAMBLE

As the Section approaches its 25th anniversary, your leadership with an appreciation for the past, met to celebrate the present, and develop a vision for the future. The following strategic plan was developed by the Board of Directors and Committee Chairs on September 27, 1997 and is presented to the membership.

SECTION MISSION

The mission of the Orthopaedic Section of the American Physical Therapy Association is to be the leading resource for orthopaedic physical therapy. The Section serves members and represents the interests of orthopaedic physical therapy by fostering high quality patient care and promoting professional growth through:

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

SECTION VISION

The Orthopaedic Section is the leader in advancing orthopaedic physical therapy practice through the professional development and increased involvement of members through bold and innovative education, practice, and research initiatives while maintaining fiscal and ethical accountability.

GOALS

1. Facilitate continued professional development in orthopaedic physical therapy clinical practice.
2. Create dynamic leadership development programs for members.
3. Provide leadership for fostering and directing clinical research to establish outcomes effectiveness and efficacy of orthopaedic physical therapy.
4. Promote knowledge of and provide support for physical therapists as an entry point in the management of musculoskeletal dysfunction.
5. Actively strive to promote orthopaedic physical therapy presence in the legislative arenas and to protect orthopaedic physical therapy practice.
6. Utilize technological advancements to educate and communicate with membership, and facilitate Section governance.
7. Generate alternate sources of revenue to increase benefits to members, protect fiscal solvency, and control costs.
8. Attain international recognition for the Orthopaedic Section.
9. Maintain current membership growth rate of 2%.
10. Develop and maintain a record of Section history (2+ years).

A Look Back...1997

Education

Combined Sections Meeting

- Each Orthopaedic Section Special Interest Group (SIG) and Roundtable has an education chair who assists in program planning for Orthopaedic Section members. Education Program Committee members assisted in program planning also. The Orthopaedic Section programming is extensive and offers many choices for the members attending CSM. Audiotapes of the programs supplemented with handouts from each speaker were available.
- At the 1997 CSM in Dallas, Texas, 24 speakers presented on behalf of the Orthopaedic Section. The Section sponsored 7 joint programs, and 4 speakers presented at the Preconference Course-Foot Orthoses: Scientific Basis and Clinical Concepts. The Section had 88 hours of programming including business meetings, platforms, and receptions.

PTA Activities

- In an effort to increase membership benefits and meet the needs of Orthopaedic Section physical therapist assistants, Gary Shankman, OPA-C, PTA, ATC was appointed to the Education/Program Committee. Gary assisted in planning the first Section programming specifically dedicated to PTAs. He also is being utilized in addressing the needs of PTAs participating in our home study courses.
- An education track for PTAs wishing to specialize in orthopaedics was initiated.

Current Concepts

- A Current Concepts course was planned for July to be held in Baltimore. There were four registrants so the course was canceled. A second course on the upper extremities was planned and held in San Diego in November; there were 47 registrants. Sydney Kim Schoensee, MS, PT, OCS spoke on cervical spine, TMJ, and upper thoracic. Jeff Ryan, PT spoke on the shoulder and elbow. Carol Waggy, PhD, PT, CHT spoke on the wrist and hand.

CD-ROM

- In an effort to utilize computer mediums and in conjunction with the American Academy of Orthopaedic Surgeons, we offered a home study course on the knee on CD-ROM. We will continue to investigate the computer as an alternate means of presenting continuing education.

Home Study Courses

97-1 The Hip and Sacroiliac Joint

- Course Information
  1. Anatomy & Biomechanic
     Tom Mayhew, PhD, PT
  2. Degenerative Conditions & Diseases
     Paul Beattie, PhD, PT, OCS
  3. Total Hip Arthroplasty & Rehabilitation
     Brian Evans, MD
  4. Pediatric Conditions & Diseases
     Cheryl Patrick, PT
  5. Evaluation & Treatment of the Hip & SI Joint from Manual Therapy Perspective
     Jeff Ellis, PT, MTC
  6. Prescriptive Exercises for Hip and SI
     Robert Spagnoli, PT &
     Jeff Ellis, PT, MTC
- 97-1 had a total of 727 registrants and exceeded our budgeted income by 23%.

97-A Clinical Approach to the Management of Arthritis

- Course Information
  1. Pathogenesis, Medical, & Surgical Treatment of Arthritis
     Debora Bancroft, MSN, RN
     Janice S. Pigg, MS, RN
  2. The Synovial Joint: Anatomy, Function, & Dysfunction
     Donald Neumann, PhD, PT
  3. Physical Therapy Management of Arthritis
     Dave Rubsam, PT
- The 97-A course was the co-sponsored course with the Affiliate Assembly. We had a total of 619 registrants and exceeded our budgeted income by 70%. (50% of the profit went to the Affiliate Assembly.)

97-2 The Elbow Forearm and Wrist

- Course Information
  1. Disorders of the Wrist and Distal Radioulnar Joint
     Carol Waggy, PhD, PT, CHT
  2. Gymnastic Injuries
     Jill Troisi, PT
  3. Peripheral Nerve Compression Neuropathies
     Carolyn Wadsworth, MS, PT, OCS, CHT
  4. Elbow & Forearm Fractures
     Rebecca Saunders, PT, CHT
     Jane Schmidt, PT CHT
  5. Athletic Injuries about the Elbow
     Lori Thein Brody, PT, SCS
  6. Reflex Sympathetic Dystrophy Syndrome
     Susan Stralka, PT
     Kelly Aiken, PT
- The 97-2 course had 641 registrants and exceeded the budgeted income by .01%.

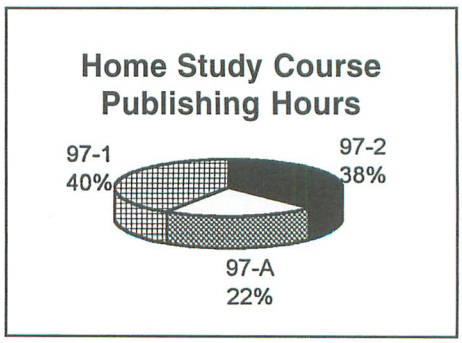
Past Homestudy Courses offered in 1997

- The three past homestudy courses from 1995 & 1996 had approximately 510 registrants and exceeded our budgeted income by 4.1%.
- The total profit for the home study series was 46% over projected figures!!

Publications

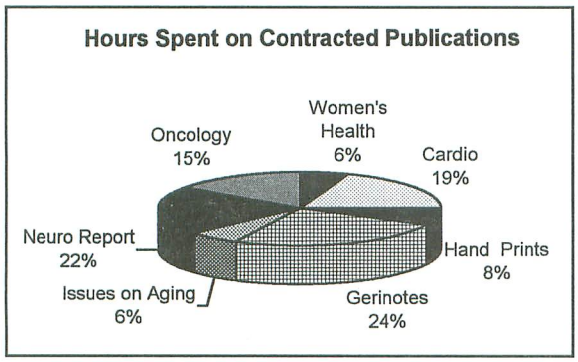
Orthopaedic Physical Therapy Practice

- *Orthopaedic Practice* came in within budget for this year. Advertising income was 78% over budget. Expenses were also under budget by 15%
- The office spent 115.5 hours working on *Orthopaedic Physical Therapy Practice*. That means 14% of their time spent on publications was spent on *OP*. *OP* averaged 36 pages per issue.



Outside Contracted Journals/ Newsletters '97

- In 1997 we published 47 publications and an average of 1,452 pages; a 36% increase in pages from 1996 and a 24% increase in the number of publications.
- In 1998 we hope to publish a total of 59 publications and 1,804 pages; a 24% increase in pages from 1997 and a 26% increase in the number of publications.
- A tracking system was implemented to accurately reflect how many hours were spent on producing each journal, newsletter, and home study series. Please see the pie chart below.



Research

- The Research Committee completed their review of 10 articles for the Rose Excellence in Research Award for 1997. The 1997 winner is Richard DiFabio, PhD, PT for his paper published in the October 1995 issue of *Physical Therapy*. The paper is entitled "Efficacy of Comprehensive Rehabilitation Programs and Back School for Patients with Low Back Pain: A Meta-Analysis."
- The Research Committee received a total of 33 poster abstracts and 48 platform abstracts for Combined Sections Meeting. These numbers are approximately 15% higher than the number of poster and platform presentations at the 1996 CSM meeting.
- The committee reviewed a total of 14 grants submitted for the Clinical Research Grant Program. Three grants were awarded for $5,000 each and two grants for $1,000 each.

Specialty Council Study Guide

- The OCS study guide was updated this year and in addition to references, included suggestions on preparing for the exam from members who have recently taken the exam.

Orthopaedic Certification Specialty Exam

- 1997 Specialty examination: 148 candidates passed the OCS examination; 215 first time candidates took the exam while there were 71 persons who retook the exam.
- Certification/Recertification forum: The inaugural forum on certification and recertification took place at CSM '97. It was highly attended by persons interested in orthopaedics. We continue to try to serve our section members through these types of venues.
- Candidates for the '98 OCS Examination: As of this date we have a total of 336 candidates qualified to sit for the 1998 OCS examination. This represents a 17.5% increase over last year. First time takers increased by 25% while the number of retakers remained fairly constant.
- Recertification Candidates: The first group of recertification candidates has applied for recertification for 1998. There have been 11 candidates thus far. The numbers will increase in the coming years.

National Board of Medical Examiners (NBME)

- The specialty council participated in the item review and exam construction in August at NBME. The quality and service of the staff at NBME was first rate. We look forward to working with them in the future.

The Item Writer's Workshop

- The Item Writer's Workshop at CSM was a very successful workshop. Both first time item writers and experienced item writers were in attendance. Several new questions were added to our test item bank. Those in attendance were quite impressed with the process and the amount work that goes into writing the questions.

Residency

- Residency Pathway to OCS: The APTA will begin credentialing residency programs in the near future. The Orthopaedic Specialty Council has proposed that a graduate of a credentialed orthopaedic residency program be immediately eligible to sit for the OCS exam. This proposal is currently being reviewed by the ABPTS. Approval is pending. This would allow two options to meet the minimum eligibility to sit for the examination: 1) the current 5-year (10,000 hours) requirement, or 2) successful completion of a credentialed orthopaedic residency program.

Marketing

- Marketing specialization is very important to the future of specialization. In the early years of specialization the values were more intrinsic. The spring meeting of ABPTS had a combined forum with council members from all specialties and ABPTS board members. Each group had a facilitator. The general conclusion was that for specialization to have value it requires both intrinsic (self-fulfillment) values and extrinsic (economic) value. The council has attended the American Academy of Family Practitioners in New Orleans in 1996 and had OCS representatives in Chicago in 1997.

Special Interest Groups

- The Specialty Council will continue to work closely with the SIGs in order to promote and encourage them to develop descriptions of their practice and subspecialty recognition process.

Practice

- New articles have come in and have been classified and listed in the Compendium of Manual Therapy and Legislative Issues. The Compendium has been distributed to each State Chapter. Advertisements in *OP* and on the section web page regarding the availability of the Compendium resulted in 100 copies being requested by Section members.

Public Relations Committee Student Guest Program

- This year marks the fourth year we have conducted the Student Guest Program. The Student Guest Program presents an excellent opportunity to foster the interest of a promising physical therapy student in the field of

orthopaedics.

- This program is open to all accredited entry-level physical therapy schools in the United States and Puerto Rico. Each eligible school is invited to submit the name of one student for inclusion in a random drawing that is held at the Section office. The winner of the drawing receives funding from the Section to attend the Combined Sections Meeting.
- Eligible students are those Orthopaedic Section members of the senior class who demonstrate an interest in orthopaedic physical therapy, who exhibit professionalism, and who are able to attend the entire conference. The Student Guest winner is expected to attend the Orthopaedic Section Business Meeting and Issues Forum during CSM, assist with audiovisuals at an orthopaedic research session during CSM, and make an oral presentation to his/her class upon returning from CSM.
- The 1997 winner was Bonnie Symes from the State University of New York at Buffalo.
- Future plans include continued promotion of the program by targeting mailings announcing the program to the clinical coordinator at each physical therapy program.

Sponsor-A-Student Program

- This program was started in the summer of 1996. The purpose of the program is to generate increased student membership while also educating the physical therapist and physical therapist assistant student about the benefits of belonging to both the APTA and the Orthopaedic Section. An evaluation survey was sent to all students who have obtained sponsorship.
- A total of 64 students have been matched with an Orthopaedic Section member willing to pay their one year membership ($15) in the Orthopaedic Section. We currently have 139 students interested in sponsorship and 5 unmatched sponsors.
- Future plans include continued promotion of the program.

Media Spokesperson Network (MSN)

- At the 1995 CSM in Reno, Nevada, the Section was charged by the membership to organize a "media strike force." The intent in developing a "media strike force" was to have a network of Orthopaedic Section members in place to allow for a quick, organized public relations response when the need arises. This network would provide the association with a vehicle to disseminate statements, opinions, etc. developed by the APTA and the Section. This network, now known as the Media Spokesperson Network, presently has commitments from 124 Orthopaedic Section members in 76 of the top 100 media markets in the U.S. An MCI fax broadcasting system is utilized to disseminate information to all spokespersons on the network.
- The following is a summary of the MSN activity to date:
  July 1996: "Couch Potato Lifestyle" press release. Rick Watson, a PR committee member and MSN member, was interviewed by the nations largest syndicated radio program, "Here's to Your Health."
  Dec. 1996: Rick Watson was again a guest on "Here's to Your Health" during the National Nutrition Association Conference in Orlando. Letter writing to register concern to the co-owners of Philosophy, a company manufacturing a line of toiletries called "Physical Therapy."
  Feb. 1997: 9th Annual Component Leadership Seminar. The agenda included items devoted to public relations and media training.
  Early April 1997: Press release on President Clinton's knee injury.
  Late April 1997: APTA's press release on President Clinton's knee injury printed. *Philosophy* responds with a letter about their physical therapy bath gel.
  June 1997: Pennsylvania PT Association appeals ruling regarding chiropractors advertising that they provide physical therapy.
- Future plans include further definement of MSN's purpose, establishing guidelines for utilizing the network, develop materials and media training opportunities for members of MSN, and continue recruitment.

APTA National Student Conclave

- The Section has been exhibiting at the APTA National Student Conclave since 1994. The Section has contributed $3,000 toward sponsorship of the student theme/talent show at the Conclave the past two years.

Career Starter Dues

- The process has been started to implement career starter dues. This option for graduating students should be in place by 1999.

Back Pain Hotline: PT '97

- The PR committee worked with APTA to line up volunteers for this hotline at PT '97 in San Diego. More than 450 calls were answered during the two-day hotline.
- Future plans include cosponsoring the hotline with APTA every three years.

OCS Marketing Project

- Development of a marketing tip sheet to assist physical therapists who become board certified as OCSs.
- Future plans include educating and encouraging members to develop PR skills relating to groups both internal and external to the Section.

Committee Activities

- Manning the Section Booth at CSM.
- Attending SIG business meetings.
- Future plans include evaluating activities implemented by APTA's PR department and develop long range plans with APTA to expand the Section's PR programs.

Awards

- The Award for Excellence in Teaching of Orthopaedic Physical Therapy recipient was Thomas G. McPoil, PhD, PT.
- The Outstanding Physical Therapist Student Award recipient was Kori Eastwood from Slippery Rock University.

Special Interest Groups

- A SIG template was drafted and work will continue on formalizing a template for distribution.
- SIGs provided excellent programming at Combined Sections Meeting in Dallas, Texas.
- SIGs go online: visit their sites linked to the Orthopaedic Section's web page www.orthopt.org.
- Orthopaedic Section Special Interest Groups in 1997 include:
  Occupational Health
  Foot and Ankle
  Pain Management
  Performing Arts

The Journal of Orthopaedic and Sports Physical Therapy 1997 JOSPT Submissions Set Records

- In 1997, the number of *JOSPT* submissions for publication continued to escalate over that of previous years (Figure1). The acceptance rate was 38%. The vast majority of the papers were research investigations, and there was a noticeable increase in the number of case studies submitted. Further, submissions from countries outside the confines of the USA increased (Figure 2) to the point where approximately one out of four manuscripts was submitted from foreign countries.

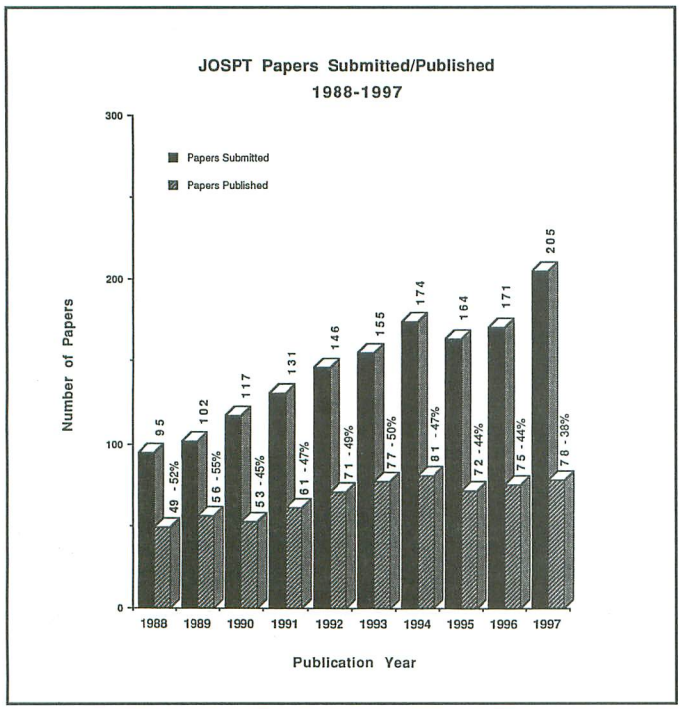


Figure 1.

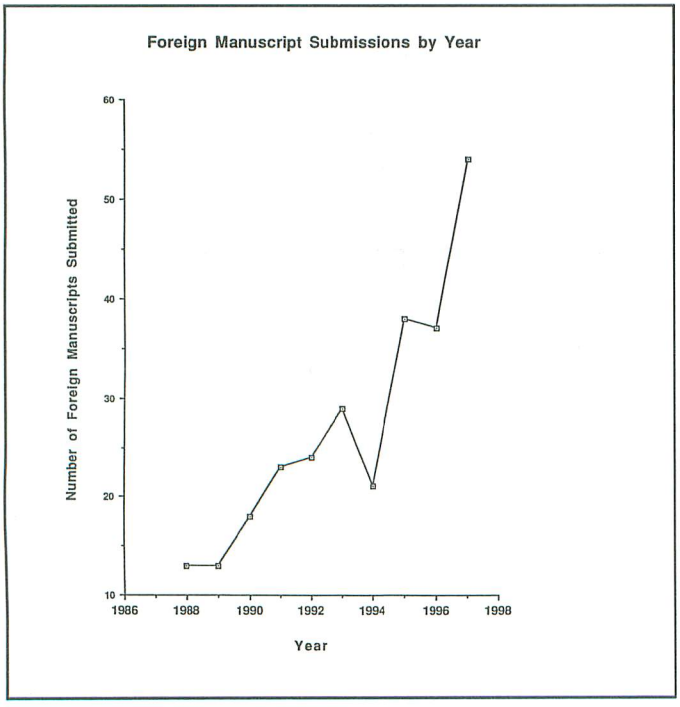


Figure 2.

Membership		
Dec. of each Year	# of Members	Percent increase/decrease
1990	11014	
1991	10413	-0.0577
1992	11527	0.1070
1993	12063	0.0465
1994	12566	0.0417
1995	12631	0.0052
1996	13162	0.0420
1997	13371	0.0159

1997 Membership Break Down						
Totals	PT's	Life Mem.	PTA	PT Student	PT Grad. Students	PTA Student
Jan. 13030	10760	204	631	1196	73	166
Feb. 13156	10797	205	633	1263	81	177
Mar. 13230	10812	207	648	1293	85	185
April 13282	10834	211	667	1301	85	184
May 13403	10982	225	730	1214	83	169
June 13020	10838	226	688	1058	131	79
July 12929	10813	227	678	1013	77	121
Aug. 13065	10847	228	687	1097	79	127
Sept. 13179	10866	227	682	1180	83	141
Oct. 13342	10882	228	689	1305	90	148
Nov. 13300	10821	241	687	1297	95	159
Dec. 13371	10,981	273	684	1188	86	159

$$$ Financial Information $$$

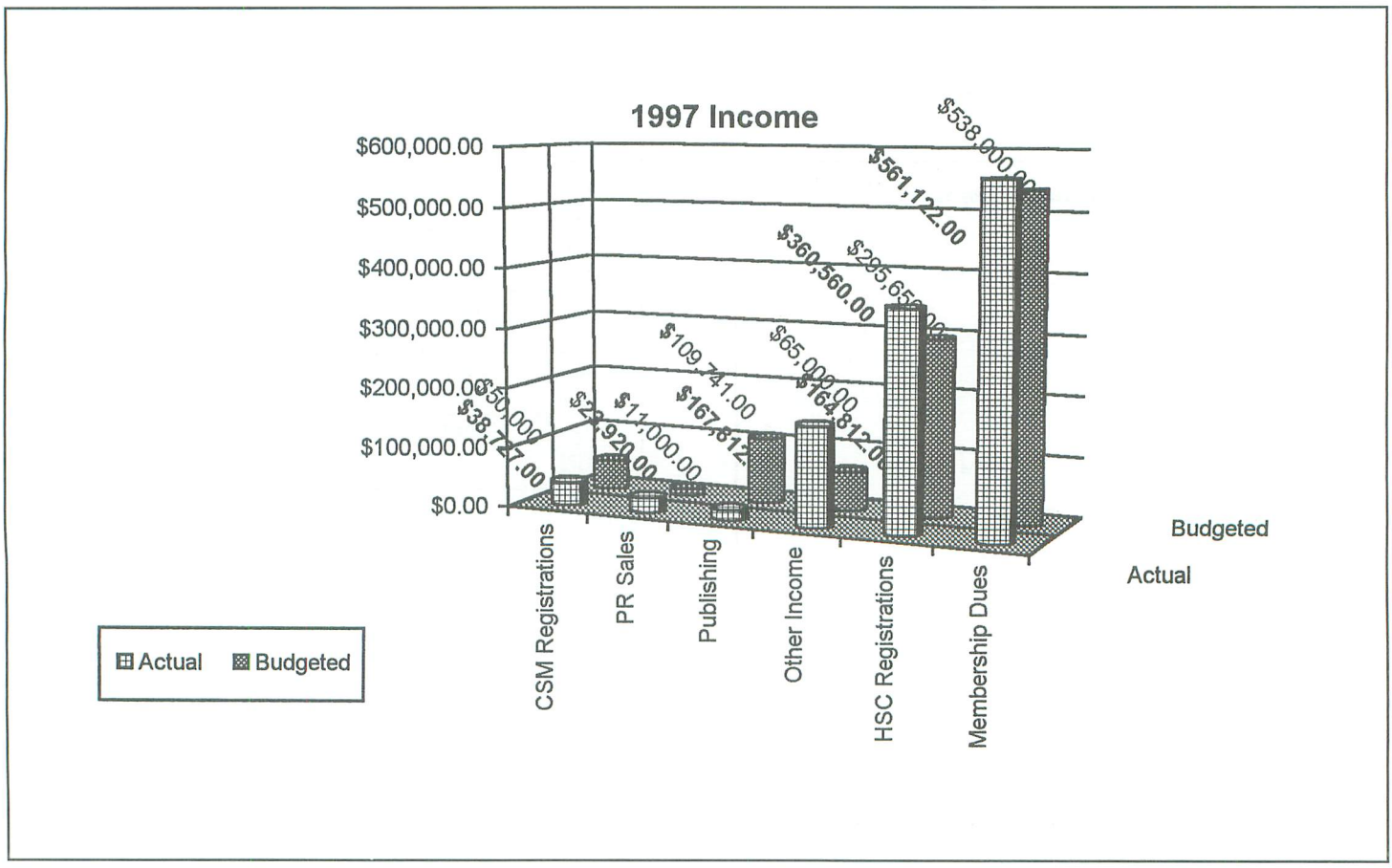
Membership grew by .02% in 1997. The Section Office worked diligently at producing three very successful homestudy courses providing current information for continuing education units. The Section Office also worked with seven other Sections in publishing newsletters in addition to publishing *Orthopaedic Physical Therapy Practice.*

The Orthopaedic Section contributed $100,000.00 to The Foundation for Physical Therapy for the Clinical Research Center on Low Back Pain.

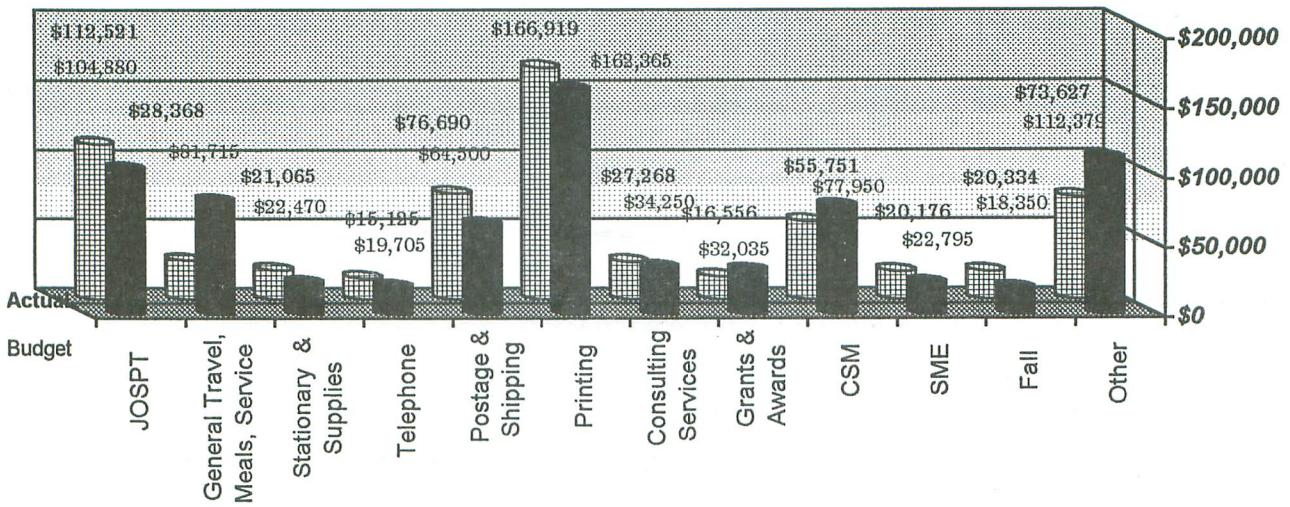
Below is a chart showing the Income and Expenses for 1997 for each of the Section's Committees and SIGs.

Committee	Income	Expenses	Committee	Income	Expenses
Governance		$46,134.90	Public Relations	$6,490.75	$16,234.17
Administration	$73,988.60	$355,697.14	Awards		$4,318.11
Membership	$564,044.02	$13,875.69	JOSPT		$112,847.73
Education	$401,750.17	$150,981.93	Nominating		$9,346.59
Publications	$149,658.47	$178,632.50	OHSIG		$5,687.47
Research		$17,617.81	PMSIG		$1,089.82
Specialty	$101,319.00	$13,195.00	FASIG		$3,198.82
Finance		$10,048.98	PASIG		$4,015.75
Practice		$2,520.43	MISC	$19,591.71	$26,770.75

The five graphs that follow include information on income, expenses, reserve funds, and Section assets and liabilities.

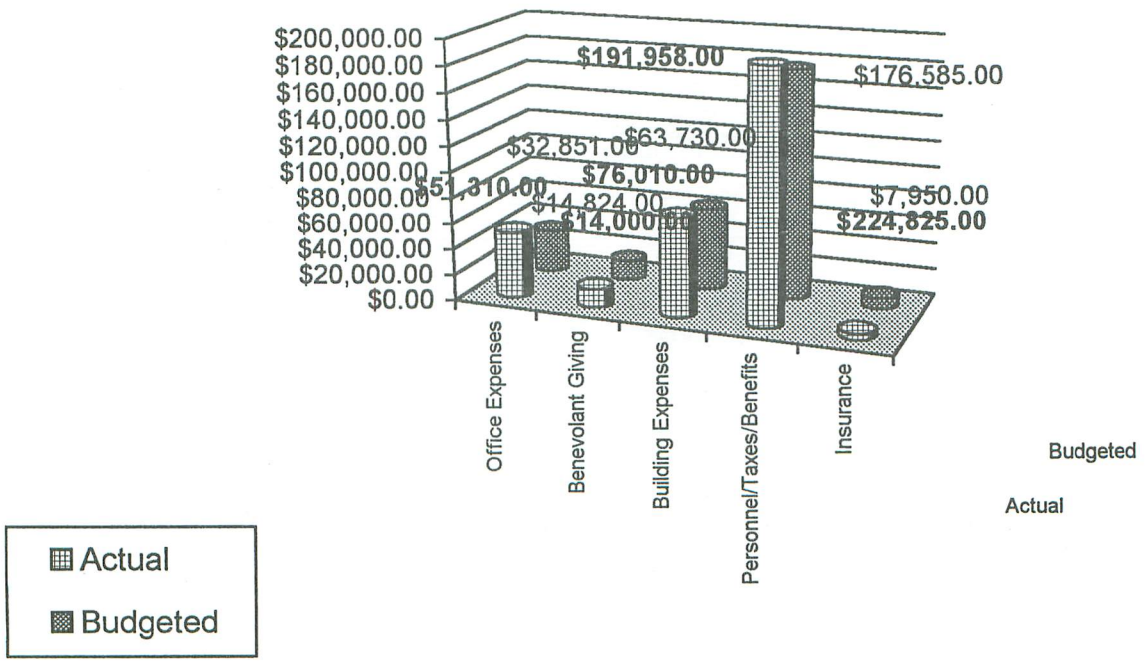


General Expenses Verses Budgeted Amounts for 1997

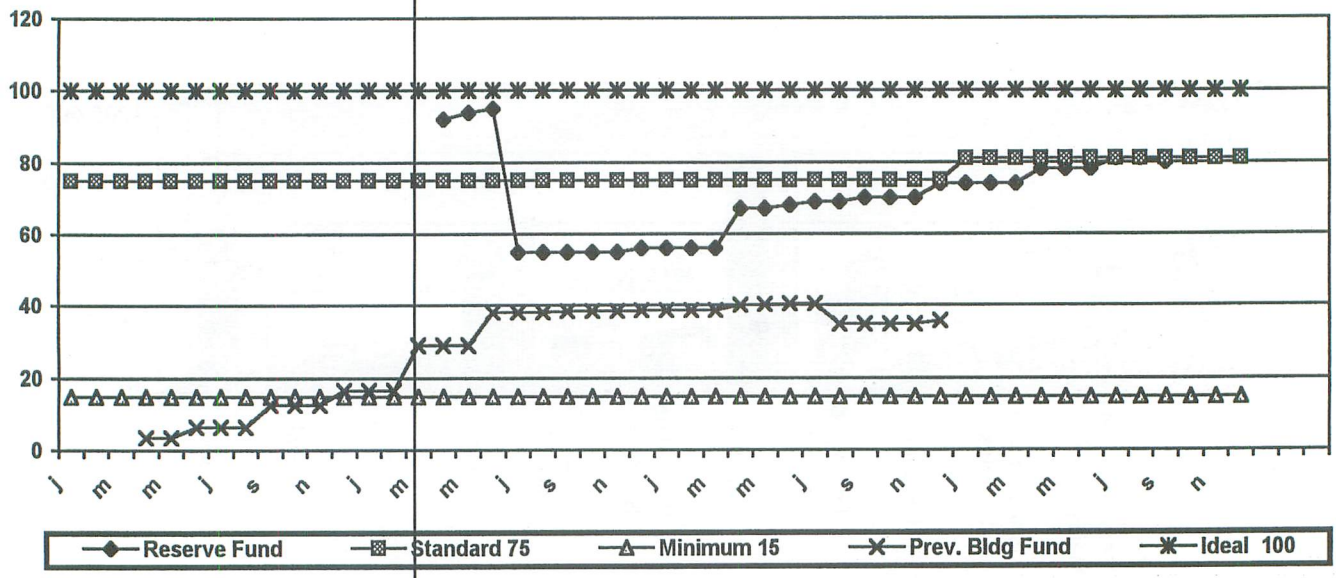


Note Actual cost is in bold, budgeted amount is in plain. Also Section Office Expenses are not included

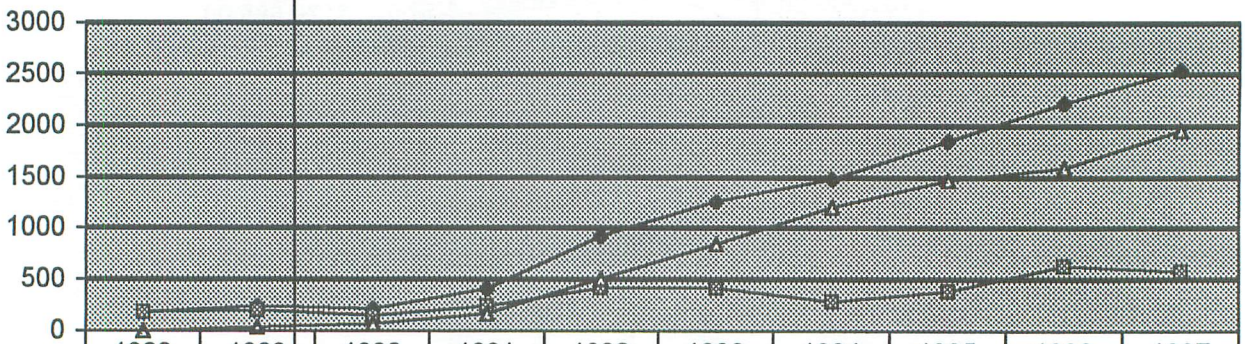
1997 Office Expenses



RESERVE FUND



YEAR END FISCAL TRENDS



	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Assests	185	243	217	410	925	1,257	1,484	1,858	2,224	2,538
Liablilities	183	203	148	240	417	413	283	382	629	577
Equity	2	40	69	170	508	844	1,201	1,477	1,595	1,961

AUDIOTAPE ADVERTISING REQUEST FORM
American Physical Therapy Association
Specialty Section

Camera-ready art to promote audiotapes from the Combined Sections Meeting '98, will be provided upon request. Please complete this form and submit to Sound Waves Productions two (2) weeks prior to advertisement due date.

Section Name: _____ Contact Name: _____

Phone: _____ Fax: _____ E-mail: _____

Advertisement Requirements

Ad Size: _____

Due Date: _____

Special Requests/Comments: _____

_____

Send Camera-Ready Art to:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Complete this form and submit to: Sound Waves Productions
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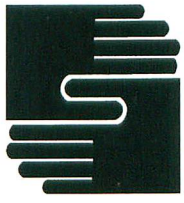

UPCOMING DEADLINES:

- June 1, 1998 - Recertification Application Deadline (for 1993 CHTs)
- July 1, 1998 - Certification Application Deadline
- Nov 7, 1998 - Certification Examination

HANDBOOK & EXAMINATION FEES:

Recertification Handbook	$35.00
Recertification Processing Fee	$325.00
Certification Handbook	$35.00
Certification Examination	$400.00

Orthopaedic Physical Therapy Practice
Orthopaedic Section, APTA, Inc.
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