ORTHOPAEDIC PHYSICAL THERAPY PRACTICE

THE NEWSLETTER OF
THE ORTHOPAEDIC SECTION
AMERICAN PHYSICAL THERAPY ASSOCIATION

VOL. 10, No. 3 SUMMER 1998

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. Level: Intermediate - Advanced

REGISTRATION FEES:	PT	PTA	STUDENT
ORTHOPAEDIC SECTION MEMBERS:	$165.00	$90.00	$50.00
NON-ORTHOPAEDIC SECTION MEMBERS:	$220.00	$125.00	$70.00

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

EQUINE PHYSICAL THERAPY I

October 9 - 11, 1998

Cornell University 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. Level: Basic/ Intermediate

REGISTRATION FEES:	PT	PTA	STUDENT
ORTHOPAEDIC SECTION MEMBERS:	$165.00	$90.00	$50.00
NON-ORTHOPAEDIC SECTION MEMBERS:	$220.00	$125.00	$70.00

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

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Editor's Note

On the Move!

Summer is over. If you live in Texas, you are glad to see it go, with those 100 degree temperatures and weeks with no rain. If you live in Florida, you too are glad to see summer go, taking those fires with it. In Memphis, it was hot and humid as usual, but it's hard to believe the summer is gone. Along with summer, the 1998 House of Delegates has passed by as well.

Friday June 5, 1998 was a historic day for the APTA. The House of Delegates passed RC 1-98 Bylaws Revision with overwhelming support. This action will restructure the organization and create the American College of Physical Therapists and the National Assembly of Physical Therapist Assistants. All voting delegates to the House will be physical therapists. Three nonvoting consultants from the National Assembly will sit in the House, as will the nonvoting Section delegates. The National Assembly of Physical Therapist Assistants will have representatives from each chapter, increasing the voice of the PTA. This creates a great deal of opportunity for all members of the association, but especially for the PTA member. Please read the article by Terry Trundle, PTA, ATC and Vice-President of the Affiliate Assembly, for his comments on RC 1-98. The next year will be an exciting one for all of us. The Association is on the move!

The Orthopaedic Section is moving forward as well. In his "President's Message," Bill Boissonnault, MS, PT gives us details of how we are progressing. In addition, the various Special Interest Groups' newsletters are located in the back of *OP* and they are full of information. Not only are there messages from SIG officers, but there are also announcements on upcoming continuing education opportunities, updates on publications, and special interest articles from SIG members. There is also a call for those interested in forming a new SIG in the area of peer review/legal practice. The Orthopaedic Section and SIGs are on the move!

In addition to our regular features, this issue of *OP* keeps us on the move with a thought-provoking commentary by Jeff Gilliam, MHS, PT, OCS which challenges us "...to provide evidence for our practice patterns..." to bridge the gap between clinical practice and research. Helene Fearon, PT and Co-Chair of the Practice Committee keeps us updated in the area of reimbursement issues with a very informative article on CPT coding. Debbie Bornmann, PTA keeps us forward-thinking on clinical education and the PTA student. Also, Terry Randall, MS, PT, OCS, ATC and Chair of the Section's Public Relations Committee gives us some tips on how to incorporate PR efforts with PT Month activities. Don't forget, October is National Physical Therapy Month. Terry also challenges us to include PR activities in every month's "to-do" list. Physical therapy on the move! I hope this issue of *OP* helps you keep up!

Susan A. Appling, MS, PT, OCS
Editor

President's Message

Our Mission

The publication of the Orthopaedic Section's Mission on page 5 marks the completion of a process started in September 1997. When you read the Mission, it's difficult to imagine the number of hours invested and the number of people who provided input that led to the creation of the two sentences that proclaim the purpose of our existence as an organization. Based on membership directives and the Section Board of Directors (BOD) initiatives, we have moved from a purpose of primarily providing resources for membership, to a mission of being an ADVOCATE and resource for the practice of orthopaedic physical therapy. Providing resources and services to membership will obviously remain a priority for the BOD, but equally as important now will be representing our membership within our national organization, including on the Chapter level, as well as outside the physical therapy community. This expanded role has led the BOD to begin assessing our organizational structure to determine if we are organized appropriately to carry out both directives in an efficient and cost-effective manner. Annually, membership will have input into our strategic plan, which should reflect the mission and vision. In addition, every 3 to 5 years the mission and vision will be formally reviewed. It would be expected that as clinical practice changes and our profession continues to evolve that this dynamic document would reflect these changes.

It's Time to Mainstream Manipulation

One of the buzzwords for our profession the past few years has been *evidence based practice*, a concept that certainly has merit. Most of the focus of this bandwagon has been questioning the utilization of components of practice that have been shown to have no or at best questionable merit. Dr. Tony Delitto recently pointed out a case on "nonevidence based practice," but from a different perspective. In the July issue of *Physical Therapy* (p 706), he states that manipulation is underutilized by physical therapists in typical outpatient clinical settings. This is despite the fact that there is "compelling evidence supporting use of manipulation for patients with acute low back pain." Dr. Delitto offers 4 possible explanations for physical therapists' reluctance to provide a seemingly appropriate service: 1. rejection of existing literature; 2. excessive commitment to particular modes of therapy; 3. tendency to discount competing therapies; 4. condition of professional uncertainty. I propose a fifth possible explanation, a lack of physical therapist preparation in the area of manipulation. While I don't profess to have in-depth knowledge of each and every physical therapist academic program's curriculum, it is my observation that entry-level training in this country in the area of high velocity thrust technique is virtually nonexistent. It would seem that academic programs would want to provide students with all of the possible effective interventions for management of the largest single outpatient population for whom physical therapists provide services. Physical therapist students should be taught the theoretical rationale for the use of high velocity technique as well as the indications, precautions, and contraindications. They should also be taught techniques for selected peripheral joints and the lumbar spine at a minimum. There are a number of therapists well qualified to provide the instruction including the over 100 Fellows of the American Academy of Orthopaedic Manual Physical Therapists. If this type of professional program training took place, I believe that Dr. Delitto's observed dichotomy would cease to exist. Lastly, I propose yet another buzzword to be tossed around our profession - *evidence based education.* Lets provide our students with all of the clinical tools that have been shown to have scientific merit.

Protect our Right to Practice!

November 1997 marked the publication of the *Guide to Physical Therapist Practice* (*PT Journal:* November 1997) that formally describes the scope of physical therapy practice. This valuable document will serve many purposes including delineating to Association Chapters what should NOT be considered negotiable when embroiled in legislative battles. In November 1997 I wrote a letter to the APTA BOD expressing the Section's concern about Chapters giving up the right to fully practice as *The Guide described* (eg, giving up joint manipulation) in order to procure a legislative victory. Also included in the letter was an inquiry that, if the BOD considered all treatment interventions described in *The Guide* "legislatively sacred" would they be willing publicly to state this? In May 1997 I received a response from Dr. Jan Richardson, President, APTA stating that during the March APTA BOD meeting the following action was taken: "Approved a motion to encourage components when negotiating legislation, to do so in a manner that preserves and protects the physical therapist's ability to provide services consistent with the *Guide to Physical Therapist Practice*." Although encourage is hardly a powerful directive, it is a welcome step in the right direction. This directive carries the responsibility of providing Chapters with the resources necessary for legislative success in the face of powerful opposition. The reply also carries the responsibility for membership to remind Chapter Executive Committees about this APTA policy when legislative strategy is being formulated. These responsibilities will be welcomed ones.

As I write this, the Section's Practice Committee is finalizing the "Manipulation/Chiropractic" Legislative Resource Manual, which will be distributed to all chapters annually. This manual is an expanded version of the Manual Therapy Compendium, which we have sent to Chapters the past two years. We continue to work closely with APTA and the American Academy of Orthopaedic Manual Physical Therapists to develop a practical and valuable resource for the Chapters. If your chapter is facing legislative challenges from Chiropractic (or other) groups regarding the ability of therapists to utilize manual therapy interventions, please remind the Chapter Executive Committee that this resource packet exists through the APTA and the Section.

Lastly, our legislative concerns extend beyond the threats from Chiropractic Associations. In this regard, I am pleased to announce that during their March meeting the APTA BOD also passed the following: "Staff to develop various resource documents (including action packets) to address the following state legislative and regulatory challenges, to include, but not be limited to: chiropractors and manipulation, mas-

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sage therapy, athletic trainers, personal fitness trainers, occupational therapists, super boards/dissolution of boards, exercise physiologists, kinesiotherapists, and orthotists and prosthetists. A final report to be presented to the March 1999 Board of Directors Meeting."

I applaud the APTA BOD for the above described policies and hope that APTA staff will continue to seek out assistance from the Components and groups like the AAOMPT regarding the make-up of these resource packets.

Etc.

Thank you office staff for the tremendous effort leading up to and during the SME.

Thank you Dan Riddle for your efforts as Chair of the *JOSPT* Editor-in-Chief Search Committee.

Congratulations to George Davies for the successful completion of his second term as President of the Sports Section. I am grateful to George for his commitment to the future of *JOSPT.*

William G. Boissonnault, MS, PT
President

MISSION

The mission of Orthopaedic Section of the American Physical Therapy Association is to be the leading advocate and resource for the practice of orthopaedic physical therapy. The Section will serve its members 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.**

SENTINEL ASSOCIATES COURSES

Sentinel Associates is committed to offering evidence-based physical therapy courses integrating clinical topics in orthopaedics and manual therapy, outcome measurement and current literature.

Measurement of Outcome in Orthopaedic Physical Therapy Practice: *A step-by-step approach for clinicians*

This unique course will provide participants with the knowledge and tools to select appropriate functional outcome measures for clinical practice and implement an outcome assessment system efficiently in a busy clinical setting. The use of functional self-report measures to establish goals, measure progress and outcome will be addressed using clinical scenarios. In addition, how to incorporate functional outcome measures into quality assurance programs and understand the benefits and limitations of physical therapy clinical databases will be discussed.

Course Faculty: Jill Binkley and Paul Stratford
Contact: Sue Berry 807-343-2104
Location: Thunder Bay, Ontario
Fri., Oct. 16 (4-8) and Sat., Oct. 17, 1998 (8:30-4:30)

Manual Therapy Approach to Assessment and Treatment of Patients with Low Back Pain: *the skills, the evidence, the outcome.*

This course will provide participants with theoretical background and practical skills of a manual therapy approach to patients with low back pain and sacroiliac dysfunction. The evaluation of patients with low back pain will synthesize practical skills with the measurement properties (reliability and validity) of tests. The theoretical basis, practical skills and evidence from the literature relating to manual therapy approaches to low back pain intervention will be integrated. A practical approach to measuring outcome for patients with low back pain in day-to-day practice will be presented. Practical, lecture and clinical problem formats will be used.

Course Faculty: Beverley Padfield, Jill Binkley, Bert Chesworth and Paul Stratford
Contact: Appalachian Physical Therapy, Dahlonega, GA at 706-864-0755
Location: Atlanta, Georgia
Friday, March 5 and Saturday, March 6, 1999

Jill Binkley, MCISc, PT, FCAMT, FAAOMPT is a clinician and clinical researcher in Dahlonega, Georgia and Assistant Professor (PT) in the School of Rehabilitation Sciences at McMaster University, Hamilton, Canada.
Bert Chesworth, MCISc, PT, FCAMT is a clinician and researcher in London, Canada. He is currently a PhD candidate at the University of Western Ontario in the Department of Epidemiology. Bert has taught extensively in post-graduate manual therapy courses.
Beverley Padfield, PT, FCAMT is a clinician and manager of Rehabilitation at the Four Counties Hospital in Newbury, Ontario, Canada. She teaches advanced manual therapy courses at the undergraduate and post-graduate levels and is an examiner in the Canadian manual therapy specialization system.
Paul Stratford, MSc, PT is an Associate Professor in the School of Rehabilitation Sciences and Associate Member in the Department of Clinical Epidemiology at McMaster University in Hamilton, Ontario, Canada.

Jill, Bert, Beverly and Paul have published over 50 papers in journals such *as Physical Therapy, Physiotherapy Canada, Spine* and *Clinical Orthopaedics and Related Research* on topics including measurement properties of physical therapy tests, evaluation of passive joint mobility and outcome measures.

For information on sponsoring these and other Sentinel courses, contact 706-216-5458

CPT-4: Know the Codes!

Helene Fearon, PT

As the reimbursement environment in physical therapy becomes more and more of a labyrinth, CPT codes are a tool that, once you understand, can help lead to more successful reimbursement of your services. When clearly understood and effectively applied for describing your clinical services, CPT codes can help convey to the payer what services were provided to the patient. Payers, referral sources, and even our patients now rely on the use of the coding system known as CPT-4 or "Physician's Current Procedural Terminology - Fourth Edition" for a description of physical therapist services. In this article I will briefly discuss the CPT coding system, the what, where, why and hows of its development over the years, as well as provide a current update as to the most recent code revisions and additions that will most likely affect how your physical therapy services are reported. The scope of applications of the CPT codes has quickly expanded to all outpatient settings including hospital outpatient rehab services as well as CORFs, rehab agencies, and skilled nursing facilities. It pays to know the codes!

What is CPT?

CPT is a comprehensive classification and nomenclature system used to accurately identify services performed by healthcare providers. The CPT system includes more than 7,300 five-digit codes, each assigned to a description of a service or procedure. Currently, in the Physical Medicine and Rehabilitation section of the CPT manual there are 46 codes that describe services that a physical therapist would most likely provide.

There are over 140 codes throughout the CPT manual that describe the scope of services physical therapists provide. Other coding systems, like the International Classification of Diseases (ICD-9), describe diagnoses. Still other coding systems, like HCFA's Common Procedural Coding System (HCPCS), describe supplies and other ancillary services.

CPT is the most commonly used system for describing services provided to your patients. It is noted as being the system that Medicare uses to identify the services provided to participants in the Medicare program, other Health Care Financing Administration (HCFA) programs, as well as reporting and documenting for most third party payers.

How is CPT Used?

CPTs primary function is to provide a common language for the purpose of documenting services provided. The CPT system works to simplify claims processing by providing an abbreviated descriptor and code suitable for use on health insurance claims forms. Other uses of CPT include providing a comprehensive and accurate account of the health care services commonly performed. This in and of itself can be a useful resource for both the provider and the payer, in terms of offering a snapshot of what services are performed and developing an evolutionary perspective of health care delivery.

CPT can provide a mechanism for the therapist to gain valuable information about the services they provide. An example would be to track the use of CPT codes to quantify the utilization or volume of specific procedures. This resource is a valuable tool that can be an efficient and effective way to do practice forecasting or reporting for credentialing purposes. Because of the current emphasis on medical fraud and abuse, it is even more important that the CPT codes are used accurately to describe the services provided. It is crucial that therapists are aware of how their services are being described by the various codes and that their documentation supports the use of the codes.

How is CPT Maintained?

CPT is updated annually through the AMA's editorial panel process. This assures that the codes reflect the most current and accurate descriptor for services provided. As new procedures and technologies become part of physical therapy practice, CPT is revised to reflect those changes through an organized and thorough process. The APTA has worked over the past 5 years to ensure that services provided by physical therapists are accurately described in CPT, by actively participating in the CPT process.

The AMA publishes the CPT manual and owns the copyright to the CPT-4 system. The AMA facilitates the maintenance of the CPT system by providing for a very comprehensive review process. Any proposals to add, modify, and delete codes go through several important steps. These steps include research, consultations, and action by AMA coding experts, the CPT Advisory Committee, and ultimately, the CPT Editorial Panel. The APTA participates by appointing a representative to the CPT's editorial panel's Health Care Professional's Advisory Committee (HCPAC). This committee, which represents nonphysician health care providers, advises the editorial panel on proposed codes. The members of the HCPAC also develop and present coding proposals pertaining to their professions. APTA has proposed and been successful in achieving code additions, deletions, and revisions each year beginning with our initial review and revision of the 97000 series, Physical Medicine and Rehabilitation CPT codes in 1995, and continuing with the most recent addition of physical therapy evaluation codes.

CPT Changes Implemented 1995-1998

In 1995 the Physical Medicine and Rehabilitation Section of the CPT manual contained a total of 30 changes. These changes were proposed jointly by APTA and AOTA and allow for more accurate descriptions of the services provided by physical therapists. These changes were significant in the following areas.

- The majority of codes were changed from describing 30 minute procedures to 15 minutes. This allows for a provider to bill for 15 minute units of service for the majority of the codes that describe their services that are time based. If a therapist treats a patient for 30 minutes using strengthening exercises, he then would use the code 97110, "therapeutic exercise to develop strength and endurance, range of motion, and flexibility, each 15 minutes" to describe the service and would indicate 2 units of this code to reflect the time spent providing the service.
- Modalities were divided into two categories, described as supervised and constant attendance. The supervised modalities are not time based and are further described as being provided to "one or more areas." This means that if a patient is provided paraffin to both the right and left hands for 20 minutes, the code 97018 would only be used once to describe that intervention.

- The constant attendance modalities are also described as being provided to "one or more areas" but these codes are time based. If the provision of ultrasound, for example entailed 30 minutes of direct contact with the patient then two units of 97035 would be indicated and the documentation would need to support the use of two units of this direct contact modality. Although "direct contact" is never defined in CPT, the intent of this descriptor is that the provider be in visual, verbal, and/or manual contact with the patient when providing the intervention the code is describing.
- Several of the therapeutic procedure codes were revised in order to provide a more accurate description of the physical therapists' interventions. The codes describing therapeutic exercise were made more specific to describe the outcome of the intervention. For example, if the therapist's goals include strengthening and increasing range of motion of an extremity, CPT code 97110, "therapeutic exercise to develop strength and endurance, range of motion and flexibility," would best describe that desired outcome. If the same goals were desired but the patient couldn't tolerate weight-bearing perhaps these goals would be better met by performing exercises in a water environment. 97113, "aquatic therapy with therapeutic exercises" would be the appropriate code to use to describe this intervention. The codes describing therapeutic procedures beginning with 97110 through 97139 (unlisted procedure code) are all described in 15 minute time frames. If a patient is seen for 30 minutes of therapeutic exercises for strengthening, then the code 97110 would be used and 2 units indicated to describe the time spent performing the intervention. The CPT code describing "therapeutic activities," 97530, is another example of a time-based therapeutic procedure code. Unlike therapeutic exercise which describes interventions that may affect a parameter of strength, ROM, or endurance, this code describes the use of an activity to improve functional performance.
- The code 97265, "joint mobilization, one or more areas" was added to further describe manual therapy techniques. The code 97250, "soft tissue mobilization" has been in CPT since 1993 and was not adequate to describe the "joint" component of interventions using manual techniques. Payment policy will often stipulate that these codes will not both be paid when billed together. Manual therapy techniques do include both a soft tissue and joint component. Other codes that describe manual therapy techniques include massage, 97124 and manual traction, 97122. These codes, which are time based, could be used in combination with the joint and soft tissue codes to describe both joint and soft tissue components. Documentation of the services must always provide the rationale for any CPT code that is used to describe your services. Look for significant changes to these manual therapy technique codes in CPT '99.
- Tests and measurements that are performed in addition to the initial evaluation are best described by a code that was also revised in 1995. 97750, "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes" describes those tests and measurements that are performed to provide additional information in order for the therapist to properly develop or change the plan of care. If performed at the beginning of the treatment plan, they may be used as adjunctive information to further define the patient's current or baseline status. If done midway through treatment plan, the test and measures could assess ongoing treatment and assess need for changing goals or work environment. If given to the patient at discharge, they could provide information upon which to base work recommendations. This code was developed so the therapist could code for those tests and measures that are performed over and above the evaluation services performed. A written report must accompany the reporting of this CPT code. This report should clearly indicate a description of the test performed, the purpose for the test, the outcome of the test, and how this information affects the treatment plan.

In 1996, the following changes to the physical medicine and rehabilitation codes (97000 series) further clarified how physical therapy services are described.

- The single code that previously described "activities of daily living" was revised to describe two services, 97535 "self care/home management training" and 97537 "community/work reintegration training." The CPT code, 97535, describes those ADLs that patients are trained in when they are in a facility or home setting (for example, ADL/compensatory training, meal preparation, safe use of adaptive equipment). Training patients for return to activities in a work or community environment (for example, avocational activities, job analysis, work modification, money transactions, taking public transportation) would be described by CPT code 97537. Both of these codes are described as "each 15 minutes." When utilizing CPT codes that describe "training," the documentation should indicate clearly the training component of the intervention and the patients' response to this training.
- A new code was developed to describe "wheelchair management/propulsion training, each 15 minutes," 97542. This code describes services provided to a client who either has been newly fitted for a wheelchair and now must learn how to safely and effectively use it in their living environment or has recently acquired new technology on an existing wheelchair and must be trained in its use. This is another "training" code, and the provider's documentation should reflect that when using this code to describe their intervention.
- The code describing "check-out for orthotic/prosthetic use, established patient, each 15 minutes," 97703, was developed to replace codes 97700 and 97701 describing "ADL, Orthotic and Prosthetic checkout." These revisions were made to better describe the interventions provided to a patient following their orthotic or prosthetic training intervention. An example is when a patient is seen to check the orthotic/prosthetic for proper fit including areas of skin irritation. The other significance of this code change, was that the deletion of the previous code describing "check-out" for ADLs, orthotics, and prosthetics was the beginning of the process to develop physical therapy evaluation codes.

1997 brought two additional changes to codes utilized by physical therapists in describing their services.

- The services describing orthotics/prosthetic training were revised to reflect a 15 minute time frame a well as to add the descriptor "fitting" to the

orthotic code. These currently read 97504, "orthotic fitting and training, upper and/or lower extremities, each 15 minutes" and 97520, "prosthetic training, upper and/or lower extremities, each 15 minutes." When providing these services, your supplies in terms of the fabrication component can be best described by utilizing the HCPCS II codes, L codes. The actual time spent in fitting the orthotic for the patient should be documented in terms of the type of orthosis and the purpose of its application, as well as the training involved for it to be effective in terms of an outcome.

- The revision of the biofeedback code also took place in 1997. This is significant in that this code is outside of the 97000 series and yet describes an intervention often used by physical therapists. This intervention is described by 90901," Biofeedback by any modality, and 90911, which describes "biofeedback training, perineal muscles, anorectal, or urethral sphincter, including EMG and or manometry." These are not time-based codes. Payment for biofeedback is often times an issue, so it is important to know that "biofeedback" in some cases is simply a tool used to perform neuromuscular re-education. Given that goal for your intervention, 97112 can also describe your services when they include using biofeedback as a tool.

The 1998 CPT includes four new codes in the 97000 series that describe evaluation services. Two of which describe physical therapy evaluation and re-evaluation, and two that describe occupational therapy evaluation and re-evaluation. These codes replace the use of the "Q" code when describing evaluation services as provided to Medicare patients under the Part B program, and also will effect the ability of therapists to use and get reimbursed from payers for the physician evaluation codes found in the Evaluation & Management section (99000) of the CPT manual.

- 97001 "physical therapy evaluation" does not have a time descriptor, therefore is reported once when describing your evaluation services. The guideline used when developing the code and when valuing for the Medicare fee schedule, was that it represents a 30 minute face to face service and is similar to the midlevel evaluation code that describes a physician evaluation (99203). Having the code listed in the physical medicine and rehabilitation section of the CPT manual allows it to be used to describe evaluation services for each incident that brings the patient to seek physical therapy care. For example, if a patient is seen initially for a sprained ankle, you evaluate and then treat the patient 4 times and discharge, then the patient returns in 6 months with a lumbar strain, that would entail a new evaluation even though you had seen that patient in the same year for a different problem. The Physician E&M codes have a rule attached that states you must use an "established patient" E&M service if you have seen the patient within a three year time period. Again, given that you can describe each new patient problem with the evaluation code, your documentation must also support that an evaluation was performed that included a thorough examination with the development of new goals and plan of care. It is recommended that the APTA's Guide to Physical Therapist Practice be utilized as a reference to assist in developing documentation formats for physical therapy evaluations.
- 97002 "physical therapy re-evaluation" is used to describe your evaluation services that are performed when you change the plan of care due to a change in the patient's condition as previously described in the initial evaluation. This code should not be used to describe each visit. It needs to be supported by documentation of a change in both the patient's status and the interventions included in your plan of care, and most important, documentation of how this was determined (examination). Medicare payment policy allows for a re-eval every 30 days, other payment policy varies from having no guidelines (documentation supporting) to 14 days for many worker's compensation fee schedules.

In addition, some general "coding tips" would include:

- A code that is time-based, describes the providers "preservice" time (eg, patient set-up, review of medical records), "intra-service" time (eg, patient treatment, visual, verbal or manual contact) and "postservice" time (eg, discharging patient from that treatment, post-treatment instruction, documentation). When utilizing a time-based code, an additional unit of time (each 15 minutes) should not be described unless 15 minutes of service time was actually performed.
- There are several hundred codes outside of the 97000 series that describe physical therapist practice. Use of these codes is often possible, but it is best to check with the payer first and to always document to support the use of these and all CPT codes.

Knowing how to describe your services and being as consistent as possible when doing so, will be one of the most important tools you can use in achieving reimbursement for your services. The "hands on" nature of what we do in physical therapy practice can only be conveyed to others effectively, for reimbursement purposes, when the codes "come to life" through their proper use and through our effective documentation.

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Helen Fearon, PT is the Practice Committee Co-Chair.

Is the Fractioning of the Physical Therapy Profession Inevitable ..... or Preventable?

Jeff Gilliam, MHS, PT, OCS

An assessment of the physical therapy profession suggests a professional paradox. While there is evidence of improvement in research by the increasing number of peer-reviewed journals dedicated to quality research in the area of physical therapy, there is also an ever increasing number of "subspecialties" that practice on the fringe of alternative medicine. Some may dismiss this commentary as an overbearing and rigid view of professional growth. However, the repercussions of practice variations that are irresponsible and often diametrically opposed to one another in their basis could eventually lead to a clear fractioning of the profession, much in the same way that the chiropractic profession split into "mixers" and "straights." While the premise for a comparison between the professions may differ, the outcome could be much the same. An inspection of physical therapy practice variations may be viewed on a continuum, with a minority of the therapeutic interventions following a research-based approach at one end, and interventions that have no evidence-based criteria at the other end. The majority of the approaches fall somewhere in the middle of the continuum, often mixing truths with half-truths. It is those that fall in the middle, which often present seductive biomechanical and physiological ploys, that are perhaps the most deceptive and lure the unknowing by a promise of "newfound" knowledge and skills that will answer their clinical frustrations.

How can we protect our profession from the propagation of unsubstantiated claims and seductive approaches to physical therapy assessment and treatment? Maybe the question is, should we even try to protect our profession? While a passive role is not implied here, neither is "policing" the profession like McCarthyism of the 1950s. "Isn't there or shouldn't there be guidelines?" Shouldn't there be guidelines which mandate that continuing education course instructors provide research-based criteria that substantiate their claims? Maybe a plan like this would work, but soon questions may surface, like who can set limits on what someone else wants to present. Possibly more conducive would be an approach that empowers therapists with evidence-based criteria with a plan that would "bridge the gap between the clinic and the research."

Ideas.....3 step plan.

1. Providing research information on-line to APTA members:

In this age of information via computers there is no reason why technology cannot be used via the professional association (APTA) to provide specific research information about specific diagnoses/treatments on-line to its members. By providing selected research articles on reliable and valid assessment procedures as well as treatment outcome studies, therapists can be assured of the most up-to-date source for information on therapeutic intervention. An expert panel would be responsible for selecting research articles.

2. Positional support by the APTA and Sections for research oriented therapeutic approaches:

By *taking a stance on therapeutic approaches* that have been substantiated by research, the Association becomes a leader in setting a precedence on the importance of following evidence-based therapy. By *sponsoring seminars* that are based on a scientific approach, the Association sets a standard and becomes a leader in continuing education.

3. More continuing education courses offered by researchers who have a clinical focus:

Those that perform research can assist the profession by bringing this information to therapists in the way of continuing education courses. By relating research findings to *pertinent clinical scenarios*, research then becomes of "real" value to therapists.

There are those who appear very opposed to research-based physical therapy, and rightfully so. When the very substance that a therapist has been practicing for the past 15 to 20 years is challenged and shown to be unreliable, not to mention invalid, cognitive dissonance develops followed by denials or worse, personal attacks on those who are trying to perform the research. Statements like "I see my patients get better," "I know my treatments work," or "Research hasn't shown anything to really work," echo throughout dialogue with the misinformed.

Who is responsible for this conundrum? Clearly our profession has been bombarded with an overwhelming number of weekend courses by "Gurus" who are selling their claims to unknowing "believers" in an effort to "cash in" before the continuing education funds have dried up, or are obsolete. However, the "Gurus" are not the only problem, as there will always be medicine men selling snake oil. The other problem is with those who understand the research and clearly see the clinical dilemma yet do not voice concern, often for fear of professional conflict. Many have become tolerant of their professional colleagues and dismiss their practice patterns as innocent ignorance. I would beg to differ, "When a patient is psychologically crippled by a continuation of 'fix it,' 'put it back in' approaches and becomes a life time physical therapy customer, *there is a problem!*" And when the majority of the professional association members along with their "leaders" allow the continuation of such ridiculous practice nonsense in their midst, then *there is a serious problem*. To suggest professional tolerance of active ignorance is to look the other way as our profession is subtly poisoned by those who prey on well intentioned, be it misinformed and misguided, clinicians.

While we all share responsibility, those who have obtained research-based knowledge as well as clinical experience, and those who are in leadership positions should take the initiative to facilitate change in a positive direction before we find our profession clearly divided. No longer should research take a back seat to the cavalier claims of charismatic "Gurus." Let us work together for a common goal: to provide evidence for our practice patterns based clearly upon the scientific method.

Jeff Gilliam, MHS, PT, OCS received his bachelors degree in physical therapy from East Carolina University and his advanced Masters in Physical Therapy at the University of Florida. Currently he is working on his doctorate degree in exercise physiology at the University of Florida. He also works at an orthopaedic outpatient physical therapy clinic in Gainesville, Florida. One of his primary professional goals is to "bridge the gap between the scientific research and clinical practice patterns."

RC 1-98

Terry L. Trundle, PTA, ATC

As a physical therapist assistant for the past 20 years who specializes in orthopaedic rehabilitation, I feel the passing of RC1-98 by the House of Delegates during PT-98 was a historical event for our profession. As you know, RC 1-98 created a new structure of the APTA with the development of the American College of Physical Therapists and the National Assembly of Physical Therapist Assistants. The relationship of the PT and PTA in the orthopaedic arena has been one of the strongest partnerships of the APTA. The APTA Board of Directors and the Affiliate Assembly Board of Directors worked very hard over the past year to secure the future of the partnership. RC 1-98 is one of the most important landmark bylaw changes in the history of the APTA. Many changes have occurred over the past few years, but nothing will have the impact on the growth of physical therapy as the results of PT-98 in Orlando.

The Orthopaedic Section of the APTA has an excellent relationship with the physical therapist assistant. With this new APTA structure it will allow the orthopaedic PTA more opportunities with the APTA. The Orthopaedic Section has shown so much support through its membership services and educational support. Our joint efforts on providing cosponsored clinical education programs have been very successful. Since our partnership has been secured, we should continue these efforts of both the orthopaedic PT and PTA to provide the advancement of clinical education. No section does this better than the Orthopaedic Section. You should feel very proud to be part of this act of unity.

I have had the pleasure of working with some outstanding orthopaedic physical therapists in my career. Through their clinical skills and leadership, I have been very fortunate to gain many opportunities within our profession.

As I have said, the partnership is secure therefore we can move ahead with some of the important problems of our profession. Jan Richardson, PT, PhD, OCS, APTA president has made this statement "Let us move forward with the expectation of a glorious future." With the leadership of the APTA and the new National Assembly of Physical Therapist Assistants we can now move our members into the next century with the united efforts of the entire profession.

As I have stated in the newsletter articles, it's time to get excited about our partnership when together we can accomplish our goals for the next century.

Thank you for allowing me to express my appreciation to the Orthopaedic Section for all their support of the affiliate members of the APTA.

Terry L. Trundle, PTA, ATC, Orthopaedic/Sports Rehabilitation Specialist. Progressive Sports Medicine and Physical Therapy, Atlanta, Georgia. Vice-President of the Affiliate Assembly.

Clinical Instruction of the PTA Student in the Orthopaedic Setting

Debbie Bornmann, PTA

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

Clinicians face daily challenges as a result of the transition into managed care, acquisitions, mergers, and HCFA legislation. Orthopaedic practice has been sent into a tailspin as a result of these winds of change. Potential PT and PTA clinical instructors may perceive that their clinical sites are too small, too big, too busy, or too specialized and that the needs of a PTA student can not be met in their particular environment. Are these valid reasons to excuse ourselves from involvement in clinical education of the PTA in the orthopaedic setting? After speaking with Physical Therapist Assistant Program educators from around the country and interviewing several clinical instructors in a variety of orthopaedic settings, it is clear that there are many ways to address the perceived deterrents to becoming a clinical instructor. Innovative PTs and PTAs are meeting their obligation to the profession in the arena of clinical education in spite of their already demanding roles as clinicians. How are clinical sites selected and PT or PTA instructors prepared for their responsibilities as clinical instructors (CI)? How do the successful instructors I interviewed integrate PTA students into the challenging orthopaedic environment and overcome obstacles unique to their individual setting? And finally, what are the individual and organizational benefits of becoming a clinical instructor of PTA students?

All PTA programs utilize CAPTE's *Evaluative Criteria for Accreditation of Education Programs for the Preparation of the Physical Therapist Assistant* as a criterion for the development of clinical sites and to determine whether supervision requirements and the program's educational objectives will be met through the clinical experience.[1] Policy and procedure guidelines for individual programs determine the clinical experience required of the CI. Marie Setley MEd, PTA, ACCE at Alvernia College Physical Therapist Assistant Program in Reading, Pennsylvania prefers that CIs have experience working with PTAs and that PTAs are employed in the clinical facility. Peter Zawicki, Director of the PTA program at Gateway Community College in Phoenix, Arizona requires that the CI has been employed at least one year in the clinical setting where they oversee students. There are many tools available as a resource for the CI who is preparing for the PTA student, and all educators I spoke with emphasized the importance of becoming familiar with the clinical practicum course outline and competencies. Sharon Yap, PTA, ACCE for the PTA Program at Indian River Community College in Ft. Peirce, Florida reports that they and many other educators are working towards empowering the student to take the lead in providing the CI with information about the educational program and the student's own personal goals. All offer workshops that are designed to assist the clinical instructor in using various evaluation and improved communication methods. Many facilities have a clinical site supervisor's handbook that sets specific institutional guidelines and policies to protect the facility, student, CI, and patient. The APTA has developed tools to facilitate and encourage successful clinical instruction. In 1997 the Clinical Instructor Education and Credentialing Program was implemented nationally. Its goal is to "enhance the education of students through comprehensive, standardized, voluntary education of clinical instructors using APTA *Guidelines for Clinical Instructors.*[2] The APTA *Normative Model for Physical Therapist Assistant Education* continues through the revision process and will prove to be a very valuable asset for the CI as will the new Physical Therapist Assistant Clinical Performance Instrument. The tools for successful preparation and student evaluation are readily accessible and becoming more consistent on a national level.

The managed care industry has worked to "motivate providers to change the way they practice" in order to "bring costs under control."[3] In the orthopaedic setting clinicians must work harder and more efficiently. How does the CI in this setting structure their time to allow for the added responsibility of a PTA student? At NovaCare Outpatient Rehabilitation in Mesa, Arizona over 50% of the patients subscribe to a managed care health plan. Bobbie Bliss, MSPT, Facility Manager and CCCE for NovaCare in the Phoenix area states that "preparation prior to the student starting the affiliation is critical to assuring both CI and student satisfaction." She reviews the educational program materials, becomes familiar with the evaluation tool, utilizes NovaCare's corporate Student Orientation Manual and starts planning her clinical schedule up to a month in advance. "Modifying my schedule to allow for regular conferences and weekly assessments and goal planning" assures that communication with the student occurs before problems arise. She plans her schedule determining which components of a patient's care are appropriate to delegate. The student is provided with the opportunity to observe as many patient evaluations as possible so they are exposed to the critical thinking and problem solving process involved in a comprehensive orthopaedic evaluation. She also solicits their input in the development of the plan of care so they can see the relationship between interpreting the evaluative data and the treatment decisions that are established. She does not expect the student to keep up with the clinic's fast pace but tempers patient care with applicable reading, communicating with other healthcare providers, and charting activities. She cites that this is not "down time" but a reflection of what actually happens in the clinic. "None of us spend all of our time treating patients." Ms. Bliss encourages outpatient managed care orthopaedic clinicians to meet the challenge of accepting PTA students stating that it's a "great way to improve and refine your time management skills," which are critical in the orthopaedic outpatient managed care environment.

Dean Volk, MPT, Clinical Director at Physicians Physical Therapy in Phoenix, Arizona is the only full time PT in the clinic and is usually working solo. He believes that preparing for the student prior to the beginning of the affiliation is key to a successful experience. He takes time to get to know the student, their learning styles, and previous experience, all which help determine the level of supervision needed. When considering taking a student, Mr. Volk points out that the physical properties of the

orthopaedic setting may be a deciding factor for the single therapist practice. His clinic is very user friendly, and he can visually keep in contact with the student who may be in the gym with a patient while he is in a treatment room. Mr. Volk appreciates the assistance a student can provide within their limitations and like all CIs I interviewed identifies the major benefit of having a student as "keeping him on his toes with his mind always on the whys" so his treatment plans never become routine.

The educators I spoke with identified that the most difficult sites to develop are in the area of acute care. Some clinicians feel that the patients are too acute, the pace is too hectic, and having students is a strain on the staff. Sheryl Carpenter, MEd, PTA, ACCE at Penn Valley Community College PTA Program tries to increase the comfort level of the PT CI by clarifying the educational expectations of the PTA utilizing the clinical competencies of the PT and PTA student as developed by CAPTE. She feels that the protocol nature of inpatient orthopaedic acute care lends itself perfectly to the PTA student. Lezlee Alexander, PT, Department Supervisor at Paradise Valley Hospital in Paradise Valley Arizona believes that PTAs need to be involved with the orthopaedic patient from the beginning to develop the ability to critically think and problem solve through the patient's rehabilitation later on. She attributes her students' success to close communication, working side by side the first week with continuous feedback, and observation of treatment procedures until a comfort level is reached by both the student and herself, which allows for more independence. The student benefits from the interdisciplinary interaction that takes place in the acute care environment and is exposed to the psychosocial aspects of care. Lezlee is also President of the Southwest Clinical Education Consortium that fosters clinician student relationships through co-operative efforts among academic programs, clinical facilities, and the APTA. There are consortiums in many areas of the United States and they are an excellent resource for clinical instructors. She points out that not only does having students keep her fresh clinically, but their enthusiasm is contagious and motivates the staff. Gale Sweeney, Staff PTA and CI at Maricopa Medical Center in Phoenix also believes that it is vital to provide the PTA with an acute orthopaedic experience. She bases her delegation decisions on observation of demonstrated skills, what clinical rotation it is for the student and her impressions following discussions about cases they review prior to treatment. Many patients are homeless or reside in shelters and designing an orthopaedic outpatient program can be a challenge. The facility is fast paced and many patients suffer from multiple complicating medical conditions. This does not stop Gale from including the PTA student in some aspect of the patient's care, for she knows that "all experience is valuable." At the Rehability Center at Casa Grande Regional Medical Center in Casa Grande Arizona, clinical instructor responsibilities are shared between 2 CIs. The clinic is very fast paced and sharing CI responsibilities makes taking a student more palatable. The student learns to adapt to two different personalities and participates in both in- and outpatient orthopaedic care.

Physical therapists and PTAs are successfully integrating PTA students into a variety of orthopaedic clinical settings. Clinical evaluation and instruction tools are readily available through educational institutions and the APTA. Students do not need to be engaged in patient care during their entire clinical day but can benefit from participating in other aspects of day to day clinical administration. Clinical instructors can share the responsibility of clinical instruction. Physical therapists and PTAs stepped forward to be our mentors and teachers in the clinic. Who will step forward to provide orthopaedic experience for today's students? Remember, as future clinicians they will impact our reputation, the profession's future, and most importantly, the well being of our patients.

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Debbie Bornmann, PTA is a part time instructor at Gateway Community College in Phoenix, Arizona.

Erratum

The Spring issue of *OP*, volume 10, number 2, contained an error in the article by Melinda Merrigan, MEd, PTA. We apologize for the misprint. On page 19, the next to last paragraph should have read:

Shankman writes of the need for communication and teamwork in his book, emphasizing the "need for immediate, open, accurate, and purposeful communication between 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 Orthopaedic and Sports Physical Therapy Sections are proud to announce the new Editor-in-Chief for *The Journal of Orthopaedic and Sports Physical Therapy*

Richard P. Di Fabio, PhD, PT

Dr. Richard Di Fabio has been in the physical therapy profession for 23 years. He is presently a Professor in the Physical Therapy program, School of Medicine, at the University of Minnesota in Minneapolis, MN. Richard started his experience as a manuscript reviewer in 1986. Over the past 20 years, he has reviewed research for journals such as *Physical Therapy, Medicine and Science in Sport and Exercise, Archives of Physical Medicine & Rehabilitation, Journal of Gerontology, Journal of Perception & Psychophysics*, and the *Journal of Neurophysiology*. Richard has experience as a special issue editor and an editorial board member for *Physical Therapy,* and was also an editor for the textbook, *Manual of Physical Therapy.*

Recognition for his work started in his college days when he graduated as valedictorian in Physical Therapy at SUNY in Syracuse, NY, and Magna Cum Laude in Education at SUNY in Cortland, NY. He continued in his career with appointments to prestigious positions: Assistant Examiner, New York State Board of Examiners; President of the University Hospitals Executive Committee; and Director of Physical Therapy at the University of Wisconsin Hospital & Clinics. Richard also received awards for academic excellence, a Traineeship from the Foundation for Physical Therapy, and the University of Iowa C.M. McCloy Scholarship for Merit.

Richard has nearly 90 publications in several areas including Orthopaedic Physical Therapy, Biomechanics, Neuromotor Control, Kinesiology of Aging, and others. Of his published works, there are 53 refereed papers in peer-reviewed journals and he has 36 publications as books, book chapters, abstracts, or proceedings. His work has received awards for outstanding clinical research including the Excellence in Research Award from the Geriatric Section and the Rose Excellence in Research Award from the Orthopaedic Section.

Richard is currently working on several research projects: "Manipulation of the Cervical Spine: Efficacy and Risks," "Randomized Controlled Trial of the Efficacy of Specific and Non-Specific Exercise for Low Back Pain," "Physical Therapy and Health-Related Outcomes for Patients with Common Orthopaedic Diagnoses," and "Physical Therapy for Temporomandibular Disorders and Health Related Quality of Life" to name just a few.

In support of his research, Richard has been the recipient of 11 funded grants. The grants have come from various foundations and universities for research primarily in the areas of neuromotor control and kinesiology of aging. Part of Richard's responsibilities as a university professor has given him the opportunity to mentor a number of doctoral and graduate students. Richard has also been invited to give numerous scientific lectures throughout North America.

The Orthopaedic and Sports Sections are very excited to have someone with Dr. Di Fabio's qualifications assume the Editor-in-Chief position for the *Journal of Orthopaedic and Sports Physical Therapy.* We look forward to working with Dr. Di Fabio as he initiates a new phase in the evolution of the *JOSPT.*

Abstracts and Book Reviews

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

Bruckner J. *The Gait Workbook: A Practical Guide to Clinical Gait Analysis.* Slack; 1988.

The purpose of this gait workbook is not only to guide the readers into a better understanding of the subject, but also to help develop their own clinical skills to improve the lives of their patients. The author states, "understanding human gait and performing a satisfactory observational gait analysis are some of the most difficult tasks a clinician can perform." With this being a main objective, the author uses a unique, workbook approach.

Throughout each of the seven chapters, the reader is encouraged to interact with others and engage through questions and gait activity. Each chapter provides numerous questions and activities, which challenge the reader to be active in learning. There is also a video that is used in conjunction with each chapter.

The first chapter of the book deals with basic concepts of normal gait. In chapter two, the author deals with normal and pathological foot and ankle function. The author breaks the particular joints down and looks at them from a different sagittal/frontal plane. Chapter 3 explains the normal and pathological knee function, with the same format as chapter 2. Chapter 4 deals with normal and pathological hip function. In chapter 5, the author looks at the normal and pathological kinematics and kinetics of head, arms, and torso. In chapter 6, the author looks at gait through the life span. I found this chapter to be especially interesting. This author has her doctorate in anthropology, so in this particular chapter, she is able to expand and go into greater depth. She does examine gait development from infancy to old age and compares the similarities and differences. Also, the author looks at some unique aspect, such as kinetics of gait. These are nonverbal messages displayed in gait - pain, fear, etc. In the last chapter, she discusses different pathological gaits and clinical examples, such as spastic cerebral palsy, transtibial amputation, spinal cord injuries, peripheral neuropathy, adult hemiplegia, Parkinson's, downs syndrome, and center of gravity problems.

For each chapter there is an answer key at the end of the book that provides complete information for the reader. It is a good reference for a student for understanding gait. However, the answer key is a bit confusing at times, because the page numbers do not correspond with the page numbers in the text. It would be nice if they could correspond, rather than put the section number only.

Overall, I found this workbook to be thorough and challenging. It requires the student and/or the practicing physical therapist to be active in their learning process about gait. The workbook, if completed, will definitely improve one's understanding of gait. Undoubtedly, this will involve a commitment of time and study. I would recommend this workbook for a PT class or study group. It is impossible to do this workbook alone, as there are too many activities that require observation of others walking. However, it does accomplish its purpose of increasing the readers' base of knowledge and giving them clinical skills to more readily help their patients. Also, the therapist is able to develop their own style within the guidelines of correct gait analysis, which is one of her main purposes.

Dan Bankson, MSPT, CSCS

Murtagh J, Kenna C. *Back Pain and Spinal Manipulation: A Practical Guide* (2nd ed.). Oxford: Butterworth-Heineman; 1997, 470 pp, soft cover, illus.

The primary objective of this book is to provide a practical presentation of a diagnostic approach to back pain. From this approach, examination and treatment techniques are presented. The authors are Australian physicians with extensive training in musculoskeletal medicine. The textbook is derived from workshops and course work held under the auspices of the Royal Australian College of General Practitioners.

The text is divided into four sections. Each section is further divided into chapters (29 total) which present clinical features, pain patterns, diagnostic approach, physical examination, and treatment for specific regions of the spine.

Within each chapter, highlighted breakout categories titled "Key Check Points" and "Practice Tips" outline general rules, important clinical guidelines and responses, and common errors or pitfalls. From these highlighted areas, readers can glean practical tips from the authors' extensive clinical experience. To integrate concepts, the final chapter of each section uses a case study format with questions and answers provided.

Section one focuses on general concepts of spinal pain, irritability, and the diagnostic approach to spinal pain. Principles and general concepts of mobilization, muscle energy technique, manipulation, and safety guidelines are also introduced. Indications, contraindications, and sequencing of treatments based on irritability and symptoms are clearly outlined.

The next three sections of the text address the cervical spine and upper limb, thoracic spine and chest wall, and lumbosacral spine and lower limb, respectively. The chapters of these sections present clinical features, pain patterns, diagnostic approach, examination, mobilization, muscle energy techniques, manipulation, exercise programs, and other treatment methods for each region of the spine. An extensive bibliography is provided at the end of the text but few citations are noted within the text.

The description of the diagnostic approach to spinal pain is thoroughly presented in the first chapter and is reiterated throughout each specific area of the spine. Tables and figures illustrating summary of diagnostic strategy model and nonmusculoskeletal sources of back pain are clearly presented and are helpful quick references. Examination procedures presented are comprehensive and complement the diagnostic approach for each spinal region.

Manipulation and mobilization techniques include text descriptions, photos, illustrations with force vector indicators, anatomic and motion diagrams. Indications, precautions, and contraindications are well defined and rationale is provided. Algorithms of treatment selection and sequencing demonstrate the authors' clinical decision making process. The psychomotor techniques described are comprehensive enough for most spinal dysfunction but are not exhaustive. The mobilization grading system is based on three stages of accessory motion of a joint with a fourth grade referred to as the manipulation stage. This grading or staging system maybe confusing to clinicians more familiar with the Maitland grading system. The manipulations referred to in the text are high velocity low amplitude thrust techniques. Muscle energy techniques are presented for the cervical and lumbar spines, but none are described for the thoracic spine and rib cage. Muscle energy techniques presented on sacroiliac dysfunction are brief

and somewhat incomplete. Other treatment methods described, such as injection therapy and manipulation under anesthesia, may not be germane to physical therapists but are informative.

Overall, I would recommend this textbook without reservation for the intermediate or experienced physical therapist and especially those clinicians involved in spinal care and manual therapy. Section and chapter organization makes for easy reading and quick referencing. The well presented diagnostic approach is clinically relevant especially in light of direct access by physical therapists and the impact of managed care. The psychomotor techniques presented are best learned if facilitated by course work, mentoring with manually trained professionals, or an appropriate residency program.

Timothy J. McMahon, MPT, OCS

Field D. *Anatomy: Palpation and Surface Markings.* 2nd ed. Oxford: Butterworth-Heinemann; 1997, 215 pp.

Anatomy: Palpation and Surface Markings presents the art and science behind anatomical palpation with photographs, drawings, and text. This second edition has improved upon the first by including full color photographs, shared labeling between the photographs, and drawings and improved index and subject headings.

The text begins by defining palpation and discussing the effects it has on patients. It includes information on different techniques of palpation and what one should feel with normal versus pathological tissue. The book is divided into sections on the upper limb, lower limb, head and neck, thorax, and abdomen. Each of these sections follows a consistent format that includes palpation of bones, joints, muscles, nerves, arteries, and veins. Joint classification and basic biomechanics are also presented. Palpation of visceral structures is included in the thorax and abdomen sections of the text.

I found the visual presentation, including photographs and drawings of the surface anatomy to be very well done. Anterior, posterior, medial, and/or lateral views were included when appropriate. Accompanying text details the anatomy and biomechanics in an easy to understand manner. It provides a thorough description of bony landmarks including attachments, bursae, and overlying nerves and vascular structures beyond what the illustrations can provide.

Photographs of the muscles of facial expression, unlike other muscles, are depicted in a contracted position that lead to better visual delineation. The section on palpation of the abdominal viscera was very important. Physical therapists are required to make accurate decisions about the appropriateness of treatment, and we need to be able to palpate abdominal structures with the same skill level applied to the extremities and spine to complete a thorough examination.

The text has its limitations. Ligamentous palpation is not presented. Although ligaments are very difficult to accurately palpate in some areas, ligaments of the knee, ankle, and elbow are vital to the complete palpatory examination of a joint. The only error I noted in the text was the mislabeling of the extensor pollicis brevis as the extensor pollicis longus in the photograph on page 53.

I highly recommend this text to physical therapy students and practicing clinicians. It will make a good addition to an introductory musculoskeletal course that includes palpation as a basic component of the course. For the experienced clinician, it will provide a guided review of palpatory anatomy.

Patricia A, Downey, MS, PT, OCS

Giles LGF, Singer KP. *Clinical Anatomy and Management of Cervical Spine Pain.* 3rd ed. Oxford: Butterworth-Heinemann; 1998, 214 pp. softcover, illus.

The complexities of the cervical spine region were highlighted throughout *Clinical Anatomy and Management of Cervical Spine Pain.* The intent of the text was to present an international review and analysis of the basic science, diagnosis, and treatment of mechanical neck pain. Subsequently to their lumbar spine text, Giles and Singer were once again successful in presenting a well organized, well referenced, and clearly illustrated text for the medical practitioner to utilize to enhance understanding and care of the cervical spine. As practitioners, we often overlook the magnitude of mechanical neck and arm pain. Although only 35% to 40% of individuals will suffer neck and arm pain during their lives; nearly 30% of such patients will develop chronic symptoms. The development of chronic head, neck, and arm pain as a result of mechanical dysfunction is entirely unnecessary. According to the authors, if the medical community understood normal erect posture, anatomy and pathology, kinematics, the clinical picture of whiplash-type injuries, radiology and clinical management of the cervical and thoracic regions, much of the chronic pain and suffering could be eliminated.

The text was divided into three sections and 12 chapters. Section I was an introduction and section II covered anatomy, pathology, and biomechanics. Sections I and II also included a chapter on whiplash injuries that was effective in highlighting the structure, function, and management of this common musculoskeletal dilemma. Section III discussed the diagnosis and management of mechanical neck pain. There was a brief overview of the medical, surgical, chiropractic, osteopathic, and physiotherapy management of the cervical region. The seven chapters in section III reviewed the following:

- Medical management of neck pain of mechanical origin by R. Cailliet of the United States.
- Surgical management of neck pain of mechanical origin by N. Jones, an Australian neurosurgeon.
- Chiropractic management of neck pain of mechanical origin by M.I. Gatterman from the Western States Chiropractic College in Portland, Oregon.
- Osteopathic management of cervical pain by a group of physicians from the United Kingdom.
- Physiotherapy management of neck pain of mechanical origin by G.A. Jull an Associate Professor of Physiotherapy at the University of Queensland in Australia.
- Contraindication to cervical spine manipulation by A.G.J. from Australia.

The strength of the text in part was due to the incorporation of excellent drawings associated with the radiographic, computed tomography, magnetic resonance imaging, and myelographic photography.

The physical therapy chapter was biased toward diagnosing the source of the pain and the manual approach to treatment of the impairment, articular dysfunction, neural dysfunction, and muscular or neuromotor system dysfunction. There was discussion about taking a thorough subjective examination and how to relate the history to the physical examination. The exercise component encouraged deep neck flexor and lower scapular stabilization. There was mention of the need to address posture, working, sporting or recreational activities, and ergonomics.

However, the complexity of the cervical spine warrants the need for the physical therapy profession to question the future direction of the management of musculoskeletal dysfunction. Should the focus be on finding the specific tissue or source of the pain? Should we instead elaborate in more detail on un-

derstanding the forces that reproduce familiar symptoms? As a profession, there should be an emphasis on education and outcomes based practice to continue to define and quantify the practice of physical therapy.

As a general text of how each profession may evaluate and treat the neck, this would be an asset to the student or clinician's library. However, the reader needs to realize that the lack of detail in a text of this size prevents an accurate depiction of the knowledge base of each profession.

Edie Knowlton Benner, MA, PT, OCS

Fagerson TL. *The Hip Handbook.* Boston, MA: Butterworth-Heinemann; 1998, 366 pages, softcover.

The purpose of this handbook is to provide a clinical resource for physical therapists involved in hip rehabilitation. Three physical therapists and one orthopaedic physician were contributing authors. This book attempts to fill a void in the knowledge base of physical therapists by combining data and theory in the successful rehabilitation of hip problems.

Chapter one is a general overview of the anatomy and biomechanics of the hip. The chapter is supplemented by many black-and-white figures of hip anatomy, and tables of the ligaments, nerve supply, origin, and insertion of the muscles of the hip, phases of gait cycle, and forces and pressures at the hip for various activities.

Chapter two is a thorough compilation of the diseases and disorders common at the hip. Each disease and disorder is defined, followed by epidemiology, clinical and radiologic features, diagnostic criteria, and management. Included for each disease and disorder are "hot tips," such as "Always suspect avulsion fracture possibility in nontraumatic athletic injuries to the hip or pelvis" for stress fractures. Pediatric hip disorders are included in this chapter.

Chapter three is a review of the pertinent aspects of an examination and evaluation of hip joint problems. Aspects of a lower quarter screening examination are listed, followed by the components of a specific hip examination. Included in this chapter are examples of patient history and examination forms. Appendices detail special tests and differential diagnosis of common hip disorders.

The next three chapters address treatment approaches for hip problems. Chapter four focuses on physical therapy for hip dysfunction. I found the discussion of diagnosis and treatment planning an excellent introduction to treatment intervention. The emphasis on treatment intervention in this chapter is exercise and manual techniques. Information on application of physical agents is brief. Chapter five is an overview of surgical treatment for the hip, written by an orthopaedic surgeon. The descriptions of various surgical approaches and their relevance to postoperative rehabilitation is clear and concise. This chapter will particularly interest therapists in acute care and subacute rehabilitation of hip replacements and hip fractures. Postoperative physical therapy is the subject for chapter six. Included in this chapter is a sample clinical pathway for total hip replacements and a hip surgery discharge planning algorithm.

Chapter 7 is a brief review of diagnostic imaging, focusing on plain films. The final chapter is a discussion of assessment of outcomes for hip rehabilitation. Tables of hip ratings system and functional ability scales are included. An extensive list of references follows this chapter.

This handbook is somewhat limited in depth. Some terms, such as "suction phenomenon" (Chapter 2) and "torque test" (Chapter 3) are not fully defined. This handbook will need to be supplemented by texts with greater detail for a full understanding of the hip.

The Hip Handbook is a noble attempt to provide a complete clinical resource on rehabilitation of the hip. Clinicians can use this handbook as a ready reference for research-based examination, diagnosis, and planning of treatment interventions for patients with hip problems. Physical therapy students may find the handbook helpful in planning their study of the hip.

Thomas Patrick Nolan Jr., MS, PT

Cailliet R. *Foot and Ankle Pain.* 3rd ed. Philadelphia: FA Davis; 1997, 287 pp. softcover, illus.

Rene Cailliet's third edition of *Foot and Ankle Pain* is intended to provide the health care professional with an in-depth and comprehensive review of the etiology and management of foot and ankle disorders. This particular edition has been modified to include a separate chapter on examination of the foot and ankle and to highlight clinical disorders such as reflex sympathetic dystrophy and diabetic conditions.

The first three chapters of this book are dedicated to providing the reader with an overview of anatomy, gait, and examination techniques with respect to the foot and ankle. The remainder of the text includes specific chapters on the adult and pediatric foot, ankle injuries, neurological, dermatological, diabetic, and vascular disorders.

Noteworthy features of this book include an extremely well referenced chapter on RSD that provides the reader with an in-depth historical, epidemiological, and management perspective on the syndrome. Also of note are the excellent illustrations drawn by Dr. Cailliet that are generously distributed throughout the text. These illustrations allow the reader additional opportunity for appreciation of the material. Another strong point of this text is the comprehensiveness of information presented. For example, several chapters are dedicated to the etiology of pain according to various locations within the foot such as the great toe, heel, and ankle. Furthermore, an important theme consistent throughout the text is Cailliet's emphasis of the importance of evaluating proximal relationships in the lower kinetic chain such as the tibia and femur. Finally, while the suggestions on management of foot and ankle problems are fairly basic, the strong etiologic concepts presented in this text should enable the physical therapist to augment their treatment protocols with more precise and effective techniques.

Amidst the excellent and well written pages of this text, there were two chapters which I found to be of relative weakness. First, in chapter two, Dr. Cailliet describes the function of the foot during the gait cycle. However, his use of the determinants of gait to instruct the reader falls short of providing a thorough description of joint kinematics of the foot and ankle. Second, chapter three discusses the examination of the foot and delivers an excellent review of palpation, mobility, and strength assessment. It fails, however, to describe the specific tests related to identification and evaluation of biomechanical abnormalities (ie, varus/valgus deformities of the rearfoot and forefoot) — tests which are integral to evaluation and subsequent treatment of the foot and ankle.

Overall, Cailliet's contribution is a welcome and necessary addition to the foot and ankle literature in that it provides a thorough and easy to read description of foot and ankle disorders. I would highly recommend this to any physical therapist, regardless of discipline, who treats patients with foot and ankle pain. This book would also be appropriate for the physical therapy student who is trying to gain a better understanding of foot and ankle pathologies.

Phyllis A. Clapis, MS, PT, OCS

Orthopaedic Section - CSM Preliminary Programming Schedule
Seattle, Washington, February 3-7, 1999

WEDNESDAY
February 3, 1999

8:00-5:00
Management of Patellofemoral Pain:
A Comparison of Treatment Strategies"
Christopher Powers, PhD, PT
Mark Looper, PT
Kate Grace, PT
Ron Hruska, PT

THURSDAY
February 4, 1999

12:30-2:30
Captivating Learners:
Teaching Strategies to Maximize Interest
Jody Gandy, PhD, PT

3:30-4:30
Update on Orthopaedic Specialty Certification
Jean Bryan, PhD, PT, OCS
Bill O'Grady, MS, PT, OCS, MTC
Michael Cibulka, MHS, PT, OCS

1:00-4:30
Research Platforms Session A & B

6:30-7:30
Meet the *JOSPT* Editor Reception

FRIDAY
February 5, 1999

8:00-10:00 12:30-2:30
Research Platforms Session A & B

8:00-10:30 3:30-8:30
Orthopaedic Section BOD Meeting

8:30–10:30
Performing Arts SIG Programming
Moderator: Nicholas Quarrier, PT, OCS

8:30-9:30
Becoming a Performing Arts Mentor
Helen Mason, PT, PhD
Lisa Maatz
Brent Anderson, PT
Shaw Bronner, PT
Marshall Hagins, PT

9:30-10:30
Getting Your Research Started
Nancy Byl, PT, PhD

8:30-10:30
Occupational Health SIG HOT Topics
Moderator: Jenn Panageas, MSPT

8:30-9:30
Injury Prevention Exercise Programs - What Works, What Doesn't

9:30-10:30
Outcomes Driven Management of Industrial Low Back Injuries
Frank J. Fearon, DPT, OCS
Jurine D. Hatten, BS

9:30-10:30
TMJ: Searching for the Source of Symptoms
Alexa G. Dobbs, PT,OCS, COMT

12:30-4:30
Foot & Ankle SIG Programming
Moderator: Mark Cornwall, PT, PhD, CPed

12:30-1:30
Conservative and Surgical Management of Ankle Arthritis
RobRoy Martin, PT
Joseph Tomaro, MS, PT, ATC

1:30-2:30
Measuring Functional Outcomes for the Foot
Nancy Henderson, PT, PhD, OCS

2:30-3:30
Foot Orthotic Materials: What, Why, and When
Jim Birke, PT, PhD

3:30-4:30
Management of Hallux Limitus and Rigidus
Brian Pease, PT

12:30-3:30
Pain Management SIG Programming
Moderator: Joe Kleinkort, PhD, PT

12:30-2:30
Developing an Integrated Approach to Pain Management
G. Frank Lawlis, PhD

2:30-3:30
Rapport, Relationship, and Compliance: Physical Therapy and the Difficult Patient.
Lisa Janice Cohen, MS, PT, OCS

12:30-4:30
Essential Components for Developing a Clinical Residency Program
Carol Jo Tichenor, MA, PT
Joe Farrell, MS, PT
Gail Jensen, PhD, PT
Mike Rogers, PT, OCS,
George Davies, MED, PT, ATC, SCS, CSCS
Toby Long, PhD, PT

12:30-2:00
JOSPT Board of Directors

2:30-3:30
Veterinary SIG Business Meeting

6:00-7:00
Performing Arts SIG Business Meeting

7:00-9:00
Performing Arts SIG Reception

SATURDAY
February 6, 1999

8:30-10:30
Orthopaedic Section Business Meeting

12:30-3:30
Orthopaedic PTA Roundtable Programming
Moderator: Gary Shankman, PTA, ATC, OPA-C

Hip Fractures: Practical Treatment Strategies for the PTA
Trudy Goldstein, PT
Christopher Scott, BS, PTA, CSCS

12:30-4:30
Veterinary SIG Programming
Moderator: Lin McGonagle, MSPT, BS - Animal Science
David Levine, PhD, PT
Leslie Kerfoot, PT, President of CHAP
Wesley Rau, PT
Lin McGonagle, MSPT, BS - Animal Science

12:30-3:30
Manual Therapy Roundtable Programming
Moderator: Laurie Kenny, PT, OCS
Treatment for the Neurovascular Consequences of Repetitive Strain Injuries
Peter Edgelow, MA, PT
Patty Zorn

12:30-3:30
Performing Arts SIG and Occupational Health SIG Programming
Moderator: Nicholas Quarrier, PT, OCS

12:30-1:30
Ergonomic Solutions for the Injured Musician
Lori Stotko, OTR, CHT

1:30-2:30 CTD Prevention: Creating and Selling a Program
Mary Davenport, PT, OCS

2:30-3:30 Psychosocial Aspects of the Workplace: Issues Around Performance
Linda Hamilton, PhD

2:00-5:00
Research Platforms Session A

2:00-5:30
Research Platforms Session B

3:30-5:00
OHSIG Business Meeting

3:30-4:30
Orthopaedic PTA Roundtable Business Meeting

3:30-4:30
Manual Therapy Roundtable Business Meeting

3:30-4:30
Pain SIG Business Meeting

3:30-4:30
Foot and Ankle SIG Business Meeting

6:30-8:00
Orthopaedic Section Awards Program

8:00-10:00
Orthopaedic Section Anniversary Party

SUNDAY
February 7, 1999

8:30-10:30
PT Marketing Strategies for the Future
Rick Watson, PT

8:00-12:00
Occupational Health BOD Meeting

Orthopaedic Section, APTA, Inc.
Scientific Meeting and Exposition
June 5, 1998
Orlando, Florida
Board of Directors Meeting Minutes
(7/20/98)

The Scientific Meeting and Exposition Board of Directors meeting was called to order by President Bill Boissonnault in Orlando, Florida on Friday, June 12 at 8:00 AM.

ROLL CALL:
Present
Bill Boissonnault, President
Nancy White, Vice President
Dorothy Santi, Treasurer
Elaine Rosen, Director
Joe Farrell, Director
Lola Rosenbaum, Education Chair
Phil McClure, Research Chair
Helene Fearon, Practice Chair
Carolyn Wadsworth, HSC Editor
Fran Welk, APTA Board Liaison

Terri DeFlorian, Executive Director
Sharon Klinski, Publishing Manager
Susan Appling, OP Editor

Absent:
None

MEETING SUMMARY:

Minutes from the CSM Board of Directors meeting (February 13, 1998) and Finance Committee Conference Call (April 30, 1998) were approved by the Board as printed and with editorial changes. The agenda for the SME Board of Directors meeting dated June 5, 1998 was approved as printed.

=MOTION 1= To change the wording in the following bylaw articles to be consistent, stating appointment by the President with the advice and consent of the Board of Directors.

ARTICLE VII. OFFICERS
BOARD OF DIRECTORS
EXECUTIVE COMMITTEE

Section 2: Board of Directors

B. Duties and Responsibilities

4. The *President* shall appoint the Education Program Chair *with the advice and consent of the Executive Committee.* The Education Program Chair shall serve at the discretion of the Board of Directors.

ARTICLE VIII. COMMITTEES

Section 1: Standing Committees

A. Names

The standing committees shall be the Education Program, *Orthopaedic Physical Therapy Practice*, Research, Specialization, Finance, Practice, Public Relations, Awards, and Nominating.

B. Appointment and Tenure

The chair-persons of the standing committees shall serve for a term of three (3) years or until their successors are appointed. Committee members shall also serve for a term of three (3) years. Committee members, except the Nominating Committee, and chair-persons shall be appointed by the Section President with the advice and consent of the *Executive Committee.* Committee members and chair-persons shall be current Section members in good standing.

Section 2: Finance Committee

B. The Treasurer shall be the Chair of the Finance Committee and *recommend committee members for approval by the Executive Committee.* **=PASSED=**

SS: To provide consistent language for the appointment of committee chairs for all Section committees.

=MOTION 2= Put forth the following bylaw amendment to the membership:

ARTICLE VIII. COMMITTEES

Section 1: Standing Committees

B. Appointment and Tenure

Include the following immediately after the first sentence: No committee chair shall serve more than two (2) full consecutive terms as chair of the same committee. No committee chair shall serve more than four (4) complete consecutive terms as a committee chair of any committee. **=PASSED=**

SS: To create consistent language for appointment tenure between committee chairs and elected officers.

=MOTION 3= Videotaping the Section's Award Ceremonies and Receptions at CSM will be done by the APTA audio and video company. **=PASSED=**
Fiscal Implications: $500 - 600 per CSM.

=MOTION 4= The following information will be included on each SIG website:

a. Bylaws
b. Membership list
c. Upcoming educational programming

Articles from SIG members can not be posted on the web site unless they have already been published in OP but an abstract of the article can be posted. Anything other than what is listed here needs approval from the Section Board liaison prior to posting on the SIG web site. **=PASSED=**

=MOTION 5= Charge the Public Relations Committee to promote the Section's 25th anniversary nationally through the media, specifically TIME magazine (contact Elaine Rosen for contact person). Work with Alexis Waters at APTA also. **=PASSED=**

=MOTION 6= Home study courses designated for PTAs will only grant CEU credits to PTAs. Registration, however, is open to everyone. **=TABLED UNTIL THE FALL MEETING=**

=MOTION 7= Request one extra day per diem for Susan Appling to attend the Fall Board Meeting in La Crosse, 1998 to thoroughly review the publishing process from start to finish. **=PASSED=**
Fiscal Implication: $195 to come out of the miscellaneous fund.

=MOTION 8= Charge the Research Committee to investigate three to four topic areas for a meta-analysis study along with a budget needed to complete the study and bring back to the Fall Board Meeting in 1998 for approval. **=PASSED=**

=MOTION 9= Charge Phil McClure to write a letter to Jennifer Gamboa outlining the discussion and plan for the IRB issue as discussed at the SME Board meeting in June 1998. **=PASSED=**

=MOTION 10= Continue to have the Section develop outside income sources such as but not limited to Section publications, home study courses, and co-sponsored seminars with Sections and SIGs and the Finance Committee develop office re-structuring with this as a goal. **=PASSED=**
Fiscal Implications: President and Treasurer to meet with outside consultant. Two airfares and two days per diem, approximately $1,330.

=MOTION 11= The Section hire an outside consultant knowledgeable in re-structuring or structuring non-profit educational organizations to review and alter (if necessary) the plan developed by the Finance Committee. **=PASSED=**
Fiscal Implications: $7,000 (guesstimate)

=MOTION 12= Updating the compendium document will fall under the Practice Committee's responsibilities at the conclusion of the SME meeting 1998. **=PASSED=**

=MOTION 13= Charge the Public Relations Committee to contact the Private Practice Section about exhibiting at the Academy of Family Physicians annual meeting. Also contact the Sports Section regarding exhibiting at the American Academy of Orthopaedic Surgeons annual meeting. Include in the Public Relations budget for 1999. No staff would attend these meetings. The Public Relations Committee is responsible for finding someone to staff the booth. **=PASSED=**

=MOTION 14= Recommendation that the Excellence in Teaching Award have the same criteria as the rest of the Section awards by including the restriction that prevents officers or committee chairs from receiving the award. **=PASSED=**

=MOTION 15= The Paris Award be consistently published in either *OP* or *JOSPT*. **=DEFEATED=**

It was decided that the criteria would be kept the way it is allowing the award winner to submit his/her lecture to either publication. It would then be up to the editor of the publication to determine whether or not to publish it.

=MOTION 16= Have the Section continue to explore the technical writer/project coordinator position for the OHSIG activity. **=TABLED=**

There is still some confusion on this issue so the Section office will check into this further with a report submitted at the Fall Meeting.

=MOTION 17= Create an International Veterinary Physical Therapy Association. **=TABLED=**

It was recommended that the Vet SIG pursue the possibility of becoming a subgroup of WCPT and bring information back to the Board meeting at CSM 1999.

=MOTION 18= Investigate and approve a Certification Process for Veterinary Physical Therapy. **=PASSED WITH THE DELETION OF THE WORDS 'AND APPROVE'=**

=MOTION 19= Approve reprinting the brochure advertising all of the home study courses available. Cost would be $4,793 (based on 10,000 pieces). **=PASSED=**

=MOTION 20= Finalize the preamble, mission, and vision statements. **=PASSED WITH CHANGES=**

=MOTION 21= Finalize the goals and objectives. **=PASSED=**

=MOTION 22= Finalize the strategies. **=TABLED=**

The strategies will be sent to the Board of Directors only. They will rank order the future strategies listed under each objective and send their rankings to the Section office no later than July 1, 1998. The Section office will calculate the top three strategies for each objective and forward on the Finance Committee for their review and incorporation into the 1999 budget. The budget will be approved by the Board at their Fall Meeting in September.

Adjournment 3:30 PM

Orthopaedic Section, APTA, Inc. Informational Meeting Minutes

SCIENTIFIC MEETING & EXPOSITION ORLANDO, FLORIDA JUNE 6, 1998

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

A. A quorum, consisting of 20 people, was not present therefore the meeting was informational only. No motions could be brought forth from the floor and no business could be conducted.

B. Rachel Veitch, Registered Parliamentarian, was present

C. The CSM Business Meeting minutes dated February 14, 1998 will be approved at the CSM Business meeting in 1999.

II. INFORMATIONAL REPORTS

A. Clinical Residencies

The APTA appointed a five member committee to finalize the application process. Orthopaedic Section members Michael Cibulka and Joe Godges have been selected by the APTA Board of Directors to serve on the committee. Applications will be available early this fall through Jennifer Hunt in the Public Relations Department at APTA (1-800-999-2782 ext. 3216). A four hour program will be held at CSM in 1999 to assist those interested in forming a residency program on Friday, February 5 from 12:30 - 4:30 PM.

B. JOSPT

With the January 1999 issue of *JOSPT* will mark the end of the transition for our new publishing company, editor-in-chief, managing editor, and editorial office. This transition will begin July 1, 1998. The new publisher is Allen Press, Inc. from Lawrence KS; the new editor-in-chief is Richard DiFabio, PhD, PT from Minneapolis, MN; the new managing editor is Madelon Wise of La Crosse, WI. On July 7, 1998 the new parties will meet to "Kick Off' the new editorial office which will be located in La Crosse, WI. Rick DiFabio has selected a new editorial board for the Journal and their first official meeting will be in La Crosse on September 25-26, 1998.

C. EAST RIVER PROFESSIONAL PARK

After almost three years the Section has finally secured a tenant on the first floor of its office building. They are Human Development Associates and began their lease with us on June 1, 1998. They occupy approximately 1,000 square feet of the 4,800 square feet available on the first floor. The Journal editorial office will occupy 2,300 square feet and the remaining 1,400 square feet will be for the Orthopaedic Section's growth.

D. FOUNDATION FOR PHYSICAL THERAPY

The Section's Vice President, Nancy White, was appointed to the Foundation's Board of Trustees.

The final payment for the CRC on low back pain in the amount of $130,000 was paid to the Foundation in March 1998.

The Section has approved donating $100,000 to the Foundation to fund work related injury. $20,000 will go towards administrative costs and $80,000 will be split into two $40,000 grants.

E. RESEARCH COMMITTEE

The Research Committee investigated using an external agency, ie, the Rand Corporation, in doing a meta analysis. If the Section deems this is how it wants to proceed they are ready to explore and solicit proposals for its viability.

Four individuals received small grants of $1,000 or less in the Section's research grant program.

F. EDUCATION COMMITTEE

The Orthopaedic Section will be co-sponsoring a preconference course with the Sports Section at CSM 1999 titled "Management of Patellofemoral Pain: A Comparison of Treatment Strategies." The course will be on Wednesday, February 3 from 8:00 AM - 5:00 PM.

The Section business meeting will be on Saturday, February 6 from 8:30 - 10:30 AM. The roundtable for the PTAs will officially meet for the first time.

The Section is offering three weekend courses in 1998. Demystifying Low Back Pain: Integrating Research into Clinical Practice will be offered September 12-13; Equine Physical Therapy I will be offered in October; and Foot & Ankle Dysfunction: A Case Study Approach will be offered November 6-8.

In 1999 the Section will again offer the advanced review course to help individuals prepare for the specialty exam. This will be a one week course in July which will offer both parts one and two.

In 2000 the Section will co-sponsor an educational symposium with the Texas Chapter in Padre Island, TX. The Section will assist with obtaining speakers and selecting topics.

G. HOME STUDY COURSES

The average registration for each of our home study courses is 600 - 700 per series. Most are six months in length with an exam offered for those needing CEU credit. We are just starting to think about topics for the year 2000 and will be seeking authors soon.

H. ORTHOPAEDIC PHYSICAL THERAPY PRACTICE

Susan Appling is the new editor for *Orthopaedic Physical Therapy Practice*. Susan hopes to attract increased involvement from SIGs and more clinical articles to the publication. If you are interested in writing for *OP* please contact the Section office. Some changes will be made to *OP* for the Section's 25th anniversary year in 1999.

I. SECTION HISTORY

1999 will be a very big year for the Section as it celebrates its 25th anniversary. A task force headed up by Joe Farrell and Carolyn Wadsworth will write a four part series on the history of the Section which will appear in each of the quarterly issues of OP in 1999. Other activities planned include possibly having a commemorative poster made, a 25th anniversary party at CSM, and interviewing individuals who started the Section.

Please send the Section office anything you may have that is of historical interest for the Section's archives.

At the end of 1999 the Section will be in need of a Section historian. If you are interested please contact the Section office.

J. SECTION FINANCES

The Section is changing one of its investment broker from Piper Jaffray to A. G. Edwards. The Section is having its second investment broker, Linsco Private Ledger, combine the building fund with the investment reserve fund thereby eliminating the building fund.

K. COMPENDIUM OF MANUAL AND MANIPULATIVE ISSUES

The articles making up this compendium were collected, indexed, and abstracted and is available at the Section office. The compendium continually needs to be updated. Please send any applicable information to the Section office.

The Practice Committee Chairs have formulated a manual which contains the compendium in addition to legislative information. This document was finalized at SME 1998 and will be sent to all component presidents annually.

Education Committee Report

The 1999 Seattle APTA Combined Sections Meeting (CSM) is scheduled for Thursday, 2/4/99- Sunday, 2/7/99. It is an exciting program and includes multiple and varied educational sessions and opportunities to socialize. 1999 is the Section's 25th anniversary year and a celebration is planned for Saturday evening following the awards ceremony.

We will begin with a preconference course on Wednesday, 2/3/99, entitled: Management of Patellofemoral Pain: A Comparison of Treatment Strategies. Three speakers with different viewpoints on treating patellofemoral pain will present their rehabilitation programs and the rationale behind their treatment. The following 4 days will be filled with programming sponsored by the section's roundtables and special interest groups. We are also sponsoring programs with other sections and will cover topics such as developing clinical residency programs, marketing strategies, and geriatrics in orthopaedic practice. Please see our tentative schedule on page 17 of this issue.

Lola Rosenbaum, MHS, PT, OCS
Education/Program Chair

Research Committee Report

Clinical Research Grant Program

A total of 13 proposals were received and reviewed and four proposals were funded. Congratulations to the following recipients:

- Dawn Gulick, PhD, PT, ATC, $1,000 "Effects of Acetic Acid Iontophoresis on Heel Spur Reabsorption"
- Debbie Nawoczenski, PhD, PT, $4,470 "The Effect of Two Different Orthotic Forefoot Designs on Subjects' Self-Reported Functional Status and Kinematic Behavior of the Hallux-First Metatarsal Complex During Gait"
- Rene Rogers, MPT, $1,000 "The Effect of Continuous Cryotherapy on the Rehabilitation Course Following Total Knee Arthroplasty"
- Nikol Tews, PT, $5,000 "A Double Blind Study Investigating the Efficacy of Dexamethasone Iontophoresis for the Treatment of Subacromial Impingement Syndrome"

Phil McClure PhD, PT
Research Committee Chair

Specialty Council Report

1. SACE Workshop '98- The SACE workshops went well. Some new test items came out of the meeting in Boston. NBME will be getting the questions directly from the SACE members. We continue to encourage the SACE members to increase their output of questions with the hope that we can generate a second form of the exam.

2. Item Bank Management- The Council would rather have the test questions sent directly to NBME. If they need to be reviewed, it can be done during item review/test construction in August.

3. Examination Time- The Council still strongly favors (per advice of NBME) shortening the exam to 4 hours. In essence, this allows 240 minutes to take the exam allowing for better than a minute to answer each question. Both NBME and the Council feel this is ample enough time to take the examination. Moreover, it is felt by the Council to be the most cost-effective and secure method of managing the examination.

4. Recertification- The ABPTS with guidance from the council has recertified 11 persons in orthopaedics. Another individual has chosen to sit for the exam to recertify. In the future, the numbers will increase substantially. We had recommended that the portfolio template forms should be sent to all specialists (at no charge) on a disk or through the net. This would allow a more clear, efficient, and contemporaneous method to review the re-certification portfolios. It would also make it easier for the candidates to manage their portfolios. The ABPTS staff will make the PDP forms available for download from the APTA's homepage in WordPerfect, Microsoft Word for Windows, and Microsoft Word for MacIntosh to all recertification candidates.

5. Certification/Recertification Forum- The forum was highly attended by orthopaedic members. At CSM '98, the Orthopedic Section provided a room for the Specialty Council to hold another Certification/Recertification Forum. The Orthopaedic Section also published the ABPTS's PR information pages (10 pages) in its proceedings. This was provided for the Orthopedic Section members attending the conference. We were extremely pleased with the encouraging and insightful comments made by the specialists to prospective candidates. Their comments reflected the changing values in the community with respect to the value of specialization. The forum served not only as a tool to disseminate information, but it was a great internal marketing tool to our members. We highly recommend that this forum be an annual event for both CSM and SME.

6. Council Changes- Michael Cibulka MS, PT, OCS has been selected to replace Joe Godges on the Orthopedic Specialty Council. Mike comes with a lot of experience in management of test items and test construction. Although Joe will be sorely missed, we feel that Mike will make an excellent replacement. This month, Jean Bryan, PhD, PT, OCS will replace me as Chair of the Specialty Council. I know that we will be in capable hands.

7. Eligibility Issues- The Council continues to support changing the minimal eligibility to sit for the examination in orthopedics to allow graduates of a credentialed residency program to immediately become eligible to sit for the examination. At the May ABPTS meeting the Board discussed the residency issue. They will be issuing a statement in support of residencies as one pathway toward certification eligibility. At this time a decision has not been made as to what percentage of the clinical experience that a residency would replace. The board did say it would consider the council's proposal that a residency experience could replace 100% of the clinical experience if it covered all content of the DACP. There remain some things to be worked out with respect to partial credits for individuals graduating from residency programs that do not cover the entire DACP. The council will address these issues in August.

8. Internet Listing for Specialists- We would like to see both as a PR and marketing tool, all certified specialists listed on the Internet. This could be done at the ABPTS site or at a separate web page link designed to facilitate regional referrals.

9. 1998 Examination- I wish to extend my congratulations to the 233 new orthopaedic certified specialist who successfully passed this year's exam. This brings the total of certified orthopaedic specialists to 1245.

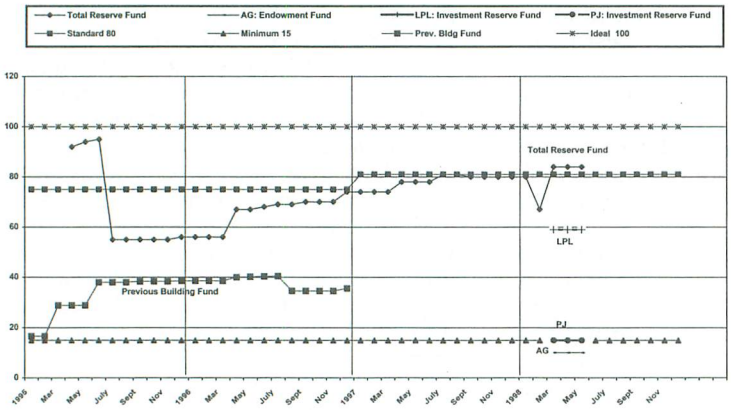
10. Test Construction Meeting- We will be meeting on August 17 in Philadelphia with NBME to construct the 1999 test. The CCE members will join the council. We look forward to a productive session.

William H. O'Grady, MA, PT, OCS, COMT
Orthopedic Specialty Council

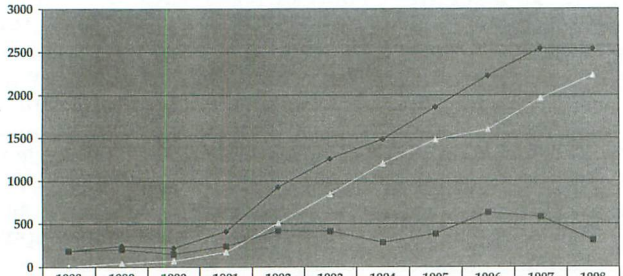
(Continued to page 22)

Finance Committee Report

ORTHOPAEDIC SECTION, APTA, INC
RESERVE FUNDS/YEAR END
JANUARY 1, 1995 TO MAY 31, 1998



ORTHOPAEDIC SECTION, APTA, INC
YEAR END FISCAL TRENDS FROM 1988 - 1998
1998 DATA IS AS OF MAY 31, 1998



	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Assests	185	243	217	410	925	1,257	1,484	1,858	2,224	2,538	2536
Liablilities	183	203	148	240	417	413	283	382	629	577	308
Equity	2	40	69	170	508	844	1,201	1,477	1,595	1,961	2228

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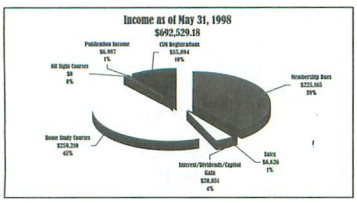
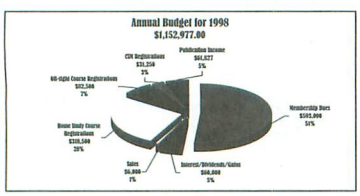
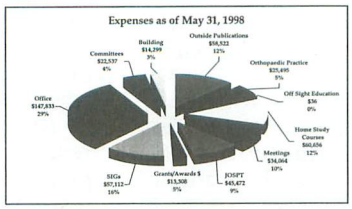
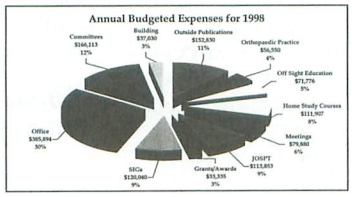
ORTHOPAEDIC SECTION, APTA, INC
BUDGETED TO ACTUAL INCOME
1998





ORTHOPAEDIC SECTION, APTA, INC
BUDGETED TO ACTUAL EXPENSES
1998





Section Members in the News

❖ ❖ ❖

Scott Stephens, MS, PT received the Lucy Blair Service Award at SME in Florida. Scott has been a resource to PTs in the area of practice and regulation issues. He has served the Orthopaedic Section as a past Practice Chair. Congratulations Scott on your achievement!

David Krebs, PhD, PT was presented the Marion Williams Award for Research in Physical Therapy. David has published many original research articles in both nationally and internationally peer reviewed journals. Congratulations David!

Congratulations Keith Taylor, PhD, PT. Keith was awarded the Dorothy Briggs Memorial Scientific Award. This award recognizes PT student members. His study presented a well-designed and carefully controlled study to examine physiologic responses of treatment in an animal model.

Thomas G. McPoil, Jr., PhD, PT received the Dorothy E. Baethke-Eleanor J. Carlin Award for Excellence in Academic Teaching. Tom is a professor in the Department of PT at Northern Arizona University. Congratulations!

Congratulations to Ward Glasoe, PT for receiving the Mary McMillian Scholorship Award in the postprofessional category.

Lori Hochman, Mary Stene, Derek Vandersloot, Samuel Ward and Margaret Traughber are the student recipients of the Mary McMillian Scholarship Award. Congratulations to all of you on your new scholarships!

Jonathan M. Cooperman, MS, PT, JD was named Outstanding Ohio Physical Therapist by the Ohio Chapter of the APTA. Jonathan is the clinical manager of the Rehabilitation and Health Center in Akron, Ohio and is the immediate past Editor of *Orthopaedic Physical Therapy Practice*. Congratulations on your achievement Jonathan!

Congratulations Nancy Krueger, PT, OCS, CHT on receiving your certified hand therapist designation. Nancy is an immediate past member of the Finance Committee for the Orthopaedic Section. Congratulations Nancy!

William G. Boissonnault, MS, PT received the Clinical Excellence Award from the Wisconsin Physical Therapy Association. Bill is the President of the Orthopaedic Section. Congratulations on your award Bill!

Congratulations Shirley A. Sahrmann, PhD, PT, FAPTA for receiving the Mary McMillian Lecture Award.

The Orthopaedic Section, APTA, Inc. would like to congratulate all of the following individuals who have recently become Orthopaedic Certified Specialists:

Roy Adams, MHS, PT, OCS
Meridith Albright, MS, PT, OCS
Robert Anderson, PT, OCS
Edward Aube, PT, OCS
Rebecca Badgerow, MS, PT, OCS
Mary Bailey, MS, PT, OCS
Peter Barnett, PT, OCS
Diane Barrickman, MA, PT, OCS
Bob Bashaw, PT, SCS, OCS
Sonya Beattie, PT, OCS
James Beazell, MS, PT, OCS
Robin Bell Dutrow, PT, OCS
Charles Bellah, PT, NCS, OCS
Denise Bellardo, PT, OCS
John Beneck, PT, OCS
Michael Biller, PT, OCS
David Black, MS, PT, OCS
Kyndy Boyle, MS, PT, OCS
Robert Boyles, MPT, OCS
Betty Branhagen, PT, OCS
Gail Brennan Polvoorde, MPT, OCS
Shirley Breuer, MA, OCS
Jean Brismee, MS, PT, OCS
Matthew Bustillos, PT, OCS
Linda Cantley, MS, PT, OCS
Jeffrey Carson, PT, OCS
Barbara Carusillo, PT, OCS
Michael Caruso, PT, OCS
Joseph Casinelli, PT, OCS
Patrick Chapman, MS, PT, OCS
Ilene Chazan, MS, PT, OCS
Scott Christensen, MPT, OCS
Genevieve Cleveland, MS, PT, OCS
Jan Collins, PT, OCS
Natalie Conway, MPT, OCS
Nancy Craven, PT, OCS
Jillian Cripps, PT, OCS
Johna Crull, PT, OCS
Maria Cuevas Marcus, PT, OCS
James Cummings, PT, OCS
Michael Danford, PT, OCS
Kelly Daniels, PT, OCS
Judith Dardzinski, PT, OCS
Janice Date, PT, OCS
Jerold Davis, PT, OCS
Peter Davis, MS, PT, OCS
Justine DeLuccio, MS, PT, OCS
Kathryn Dean, PT, OCS
Alex Delgado, PT, OCS
Steven DiPaola, PT, OCS
Elizabeth Dodd, PT, OCS
William Dodson, PT, OCS
Edsen Donato, MPT, OCS
Kevin Donnelly, PT, OCS
Robert Dowd, PT, OCS
Robert DuVall, MS, PT, OCS
John Dugan, PT, OCS
David Ebaugh, MS, OCS
Scott Edwards, PT, OCS
Tim Elser, MHS, PT, OCS
Glenda Elswick, PT, OCS
Ilonka Erades, PT, OCS
Dave Esplin, PT, OCS
Shawn Everson, MHS, PT, OCS
Ricardo Fernandez, MHS, PT, OCS
Matthew Fields, PT, OCS
Deirdre Finn, PT, OCS
Margaret Fitzpatrick, PT, OCS
Jeffrey Fultz, PT, OCS
Joy Futaba De Jaeger, PT, OCS
Pamela Gabel, MS, PT, OCS
Douglas Galvin, MHS, PT, OCS
Matthew Garber, MS, PT, OCS
Jackie Gaston, MS, PT, OCS
Lena Glasgow, MS, PT, OCS
Lee Glover, PT, OCS
Linda Glowienka, PT, OCS
Randy Green, MS, PT, OCS
Susanne Greengard, PT, OCS
Genevieve Griffin, MS, PT, OCS
Deborah Gross, PT, OCS
Marc Guillet, MS, PT, OCS
Joseph Haddad, MS, PT, OCS
Brian Hagen, MS, PT, OCS
Bill Hanlon, MSPT, OCS
Michelle Hard, PT, OCS
Scott Harmon, PT, OCS
Gale Hazeltine, MS, PT, OCS
Matthew Heintzelman, PT, OCS
H Hendricks, PT, OCS
Pamela Henry, PT, OCS
Lonnie Hergott, MS, PT, OCS
ShiuBong Ho, DPT, OCS
Kerry Hoffman, MA, PT, OCS
Clair Horn, PT, OCS
James Hosker, PT, OCS
Debra Howard, PT, OCS
Frances Huber, MS, PT, OCS
Peter Huijbregts, MS, PT, OCS
Brenda Jackson, PT, OCS
David Jewell, MSPT, OCS
Kimberly Kallick Taylor, PT, OCS
Ruth Kamenski, MS, PT, OCS
Stephen Kaschke, PT, OCS
Brent Kelln, MS, PT, OCS
Michael Kelly, PT, OCS
Kimberly Keyser, PT, OCS
Chris Kime, PT, OCS
John Krusenklaus, PT, OCS
Kathryn Kumagai, PT, NCS, OCS
Brenda Larrimer, MA, PT, OCS
Thomas Lasky, PT, OCS
Kevin Lawrence, MS, PT, OCS
Pamela Leerar, MS, PT, OCS
Peter Leininger, MS, PT, OCS
Stacy Liddle, PT, OCS
Margaret Lo Bello, PT, OCS
Everett Lohman, DPT, OCS
Gaetano Lombardo, MA, PT, OCS
Paul Lonnemann, PT, OCS
Julie Loudon, PT, OCS
Robert Lozano, MS, PT, OCS
Jane Lucas, PT, OCS
Kathryn Lyons, MS, PT, OCS
James Macaluso, MS, PT, OCS
Paul Marino, PT, OCS
Mark Mashburn, PT, OCS
Stephen Mavrakes, MS, PT, OCS
Lloyd Mayer, PT, OCS
Paula Mazur, PT, OCS
A Susan McGann, PT, OCS
Joel McGinnis, PT, OCS
Sherry McLaughlin, MS, PT, OCS
Timothy McMahon, PT, OCS
Danny McMillian, MS, PT, OCS
Jeffery Meyer, MS, PT, OCS
Valarie Meyer, MS, PT, OCS
Nancy Michler, PT, OCS
David Miers, MS, PT, OCS
Dewayne Miller, PT, OCS
Douglas Miller, PT, OCS
Stephen Molloy, PT, OCS
Thomas Moriarity, PT, OCS
Michele Mulhall, MS, PT, OCS
Diana Mullen Rivers, PT, OCS
Eileen Murphy, PT, OCS
Andrea Myszak, PT, OCS
James Nagy, PT, OCS
Billy Naquin, PT, OCS
Steven Nauert, MS, PT, OCS
Siri Njos, PT, OCS
Michael O'Hara, PT, OCS
David Okuda, PT, OCS
Kevin Okura, PT, OCS
Catherine Ortega, MSPT, OCS
Chuck Outlaw, PT, OCS
Roger Pack, MS, PT, OCS
Diane Paige, Med, PT, OCS
Eric Pallop, MSPT, OCS
Esther Perkins, PT, OCS
Bruce Peterson, PT, OCS
Roger Peterson, PT, OCS
Kathleen Pierce, MS, PT, OCS
Thomas Pietrowski, PT, OCS
Michael Ploski, MS, PT, OCS
Fredrick Pociask, MS, PT, OCS
Cindi Prentiss, PT, OCS
Jennifer Rapposelli, PT, OCS
Kelly Reed, PT, OCS
John Reneau, MS, PT, OCS
Jannette Reynolds, MS, PT, OCS
Cynthia Riggle, PT, OCS
Michael Ross, MS, PT, OCS
Robbin Rowell, MS, PT, OCS
Kerry Rudich, PT, OCS
David Rudnick, MS, PT, OCS
Michael Rymer, PT, OCS
Robert Sadowski, PT, OCS
Penelope Samuelson, MPA, PT, OCS
Mario Santomassimo, PT, OCS
James Schickling, MS, PT, OCS
Wendy Schneider, MS, PT, OCS
Jean Scott, Med, PT, OCS
Thomas Sczepanski, MS, PT, SCS, OCS
Judy Seto, MA, PT, OCS
Scott Shaffer, MS, PT, OCS
Kirk Shelley, PT, OCS
Laurie Shepard, PT, OCS
Monica Sherman, MA, PT, OCS
Ranjan Shetye, PT, OCS
Kathleen Shillue, PT, OCS
Kenneth Simons, MS, PT, OCS
Ola Simonsson, PT, OCS
Kathryn Smith, PT, OCS
Richard Smith, MS, PT, OCS
Camille Snyder, PT, OCS
Joseph Spallone, PT, OCS
Phillip Sparacino, PT, OCS
Rick St. George, PT, OCS
David Stern, PT, OCS
Itamar Stern, PT, OCS
Christine Streed, MHS, OCS
Joseph Sullivan, PT, OCS
Colleen Sweeney, MS, PT, OCS
John Swinson, PT, OCS
Peter Sydie, PT, OCS
Stephen Sylvester, PT, OCS
Gail Tate, PT, OCS
Sudhir Tawalare, PT, OCS
Mark Taylor, PT, OCS
Robert Taylor, PT, OCS
Noel Tenoso, MS, PT, OCS
Rebecca Terry, PT, OCS
Ellen Tighe, MS, PT, OCS
David Tranchita, PT, OCS
Christine Trumble, PT, OCS
Robert Turner, PT, OCS
Shlomi Tzaig, PT, OCS
Frederick Valente, MS, PT, OCS
John Van Der Karr, PT, OCS
Antonius Van Scherpenseel, PT, OCS
Ann Vendrely, MS, PT, OCS
Ross Vines, MS, PT, OCS
Donald Walsh, MPS, OCS
Michele Walsh, PT, OCS
Richard Walsh, PT, OCS
Thomas Walsh, PT, OCS
Kathleen Wasowski, PT, OCS
Dana Whitlock, MS, PT, OCS
Mary Wills, MHS, PT, OCS
Gregg Ziemke, MS, PT, OCS
Tina Zivec, PT, OCS
Thomas Zmierski, MS, PT, OCS

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 of consideration 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

Physical Therapy Month News

Everyone agrees that public relations (PR) are important but sometimes planning and carrying out a program is another story. Those of us still in private practice realize that PR is a vital part of our survival. It is a continuous process to inform the public, referral sources, and payors about the benefits of physical therapy. Physical therapists in other settings may not have the same sense of urgency, but the profession needs everyone to contribute. We all must realize that we have a responsibility to promote the profession. We all have contact with people who should have a better understanding of physical therapy.

I encourage everyone to review the June issue of *PT Magazine*. It contains the National Physical Therapy Month kit that is an invaluable resource for starting a PR event/program. There are many fears and misconceptions surrounding PR. It does not necessarily mean that you have to be forced out of your comfort zone to be effective. Not everyone needs to conduct an interview on camera. If public speaking is not your forte, don t worry. There is plenty of behind the scenes work that can be done. The PR kit gives tips on writing news releases, photography, and guidance on obtaining official proclamations from elected officials and other promotional activities. The kit provides specific examples of news releases and fact sheets that can be ready for use in local papers. Now everyone has the information and tools required to contribute to the profession's future by increasing our exposure. While you are planning events related to PT month I encourage everyone to make long term plans so that every month includes some PR/marketing activities.

Terry Randall, MS, PT, OCS, ATC
Chair, Public Relations Committee

MEMBERSHIP INFORMATION

SAVE MONEY ON YOUR SECTION MEMBERSHIP
"Career Starter Dues" allow you to save money on Section dues when you renew your membership.

With CAREER STARTER DUES you pay...
YEAR ONE: 2/3 SAVINGS
Only one-third of Section dues when you renew your membership by the end of the month following your graduation.

YEAR TWO: 1/3 SAVINGS
Only two-thirds of Section dues when you renew by the end of the month following your renewal date.

YEAR THREE: Full Section dues.

CAREER STARTER DUES allow you to continue to receive the benefits of belonging at a reduced price as you begin your career in physical therapy. However, you must renew by the end of the month following graduation to receive this outstanding two-year savings.

Call the Membership Department at APTA (1-800-999-2782 ext 3121) if you have any questions.

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

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 30, 1998 TO:
Tara Fredrickson
Orthopaedic Section, APTA
2920 East Avenue South, Suite 200
La Crosse, WI 54601

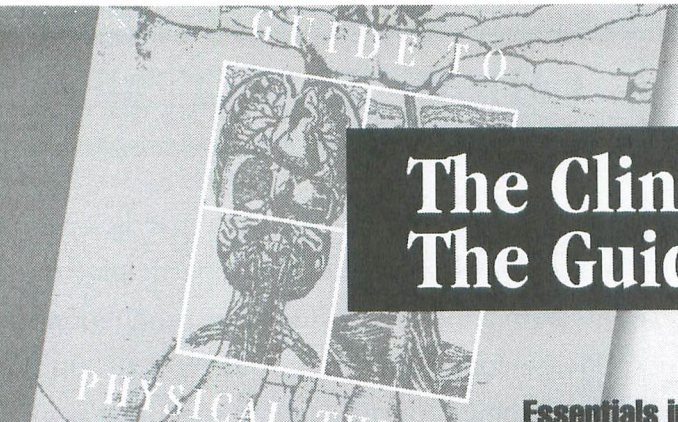
CALLING ALL "OLD TIMERS"

If you were active in the Orthopaedic Section in the 1970s, we invite you to participate in our 25th anniversary videotape production. Please consider sharing your thoughts on the development of the Section, anecdotal stories, photos, and any other information of historical significance.
Contact Linda Weaver at the Section office for details. We would appreciate your help!

Please respond no later than October 2, 1998.

APTA
American Physical Therapy Association

The Clinician You Want to Be. The Guide to Get You There!



Essentials in Applying the *Guide to Physical Therapist Practice* to Your Practice!

June 27-28 in Phoenix, AZ
September 11-12 in Philadelphia, PA
September 17-18 in Chicago, IL
November 13-14 in San Francisco, CA

APTA Members and Life Members: $295
Nonmembers: $495

Who should attend: Physical Therapist Clinicians, Educators, Administrators, and Clinical Instructors

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Please refrain from making travel/ hotel reservations until you have received registration confirmation from APTA.

Registration Form

- ❑ Phoenix, Arizona June 27-28
- ❑ Philadelphia, Pennsylvania September 11-12
- ❑ Chicago, Illinois September 17-18
- ❑ San Francisco, California November 13-14

❑ Please check here if you have any special needs in order to participate fully in this event. APTA will contact you.

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American Physical Therapy Association

UCHN058

Occupational Health Physical Therapists Special Interest Group

Orthopaedic Section, APTA, Inc.

Summer 1998 Volume 5, Number 2

The APTA Develops Press Release Highlighting Occupational Health Physical Therapy

Physical Therapists Play Key Role In Workplace Before Injuries Occur

Injury Prevention Programs A Win-Win Solution for Employees and Employer

Even before the US Occupational Safety and Health Administration (OSHA) began examining standards for workplace injury prevention, physical therapists were customizing and implementing corporate injury prevention programs in a variety of workplace settings. Companies across the country had begun to realize that such programs translated into significant cost savings, reduced liability claims, and more productive employees.

Why Companies Hire Physical Therapists

Work-site analyses, educational programs focusing on ergonomics, exercise, wellness, and physical therapy interventions, are just some of the services physical therapists are providing corporations — services nearly nonexistent in workplaces only a decade ago.

"When I began offering BACK SCHOOL ten years ago, only employees suffering from back pain were interested in attending, and only a few companies were concerned about prevention," says physical therapist Susan Grenberg of Pelham, New York-based Best Associates, a physical therapy facility specializing in injury management and prevention services. "Now we are bombarded with requests for BACK SCHOOLS, NECK AND ARM SCHOOLS, and TRAIN-THE-TRAINER programs. Interest has come full circle because companies have learned the hard way through high worker's compensation costs with increased injury frequency and severity. Many of these injuries are preventable with low or no cost ergonomic solutions."

"Through its worker's compensation insurance carrier, Hertz has worked with Set Associates to develop practical injury prevention strategies and to help assure post-injury treatment is appropriate and effective," says Andy Bohan, Corporate Safety Manager for the Hertz Corporation. "It's truly a team effort."

Today, the physical therapists are regularly retained by companies on a full or part time basis. Part time services usually involve regular on-site visits from a physical therapist or therapist team, during which work-site analyses, ergonomics classes, or injury treatment services are made available to employees. However, some companies are going the distance, hiring physical therapists full-time and setting up on-site clinics.

Modesto, California-based physical therapist George Wolff, who runs a full-time physical therapy facility at the Ernest and Julio Gallo winery, feels being on-site allows the company to internally control costs that might otherwise escalate "out-of-house." "In addition," he says, "we save the company hours of potentially lost work time since employees can receive physical therapy treatments on-site instead of commuting elsewhere. More importantly, I can develop job modifications that allow employees to re-enter the workplace much earlier. Also, employees are happier since they are kept healthy and functioning, and know they can come to me, a coworker, for advice or treatment at anytime. They see the clinic as an added job benefit, which it is."

How Physical Therapists Make A Difference In The Workplace

Orlando, Florida-based physical therapist Marilyn Roofner's clients range from Lockheed Martin and the Orlando Sentinel to Walt Disney World and Universal Studios Florida. While a physical therapist's ability to offer a variety of services is important, Roofner feels it is even more critical for them to be able to recognize and address different problems in varied workplace settings.

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"Custom design is important because each company has very different needs," explains Roofner. "For example, the stunt performers, dancers, characters, and puppeteeers at Walt Disney World and Universal Studios need the specialized services of on-site sports and dance therapists while staff at Lockheed or the Orlando Sentinel, for example, need physical therapists who can address and treat potential problems in office settings, like upper extremity cumulative trauma disorders (CTDs)."

Cumulative trauma disorders, associated with Carpal Tunnel Syndrome and similar conditions, often result from repeated and ergonomically-stressful arm, neck, and hand movements or prolonged body postures. "Reporters of deadline, for example, may spend hours in sitting positions, repeating hand movements in a stressful environment. By teaching stretching and warm-up exercises and addressing work-station and posture issues in that setting, we can help reduce the potential for back injuries and CTDs," adds Roofner. "Custom- designing programs for each client allows us specificity to address existing or potential problems in a particular setting and tailor programs and remedies accordingly."

In many cases, remedies can be simple and low-cost. For example, after a brief work-site analysis, Joe Maccio, a physical therapist with a private practice in upstate New York, was able to address a factory assembly-line problem—blamed for employee injuries and turnover—by recommending a $500 height change to conveyor workplace injuries.

Win-Win Scenario

The ultimate measure of success for physical therapists involved in work injury prevention programs is to reach a point where they focus their energies more on injury prevention and less on treatment. "In the first three years, there was an increase in visits but a decrease in severity of injuries," says Roberta Kayser, a physical therapist who operates an on-site physical therapy program at the Frito-Lay plant in Louisville, Kentucky. "Thanks to early intervention, I was able to cut my hours in the clinic facility and spend more time working on the plant floor with job coaching and teaching injury prevention."

Kayser feels the availability of physical therapy and work injury prevention programs in the workplace, full-time or part-time, creates a "win-win scenario." "Employers win because they are seeing a healthier and more productive work force." She adds, "Employees win because they can access care early, at the worksite, in the management of their problem. Additionally, physical therapists win because they can direct the care that an employee patient receives and act more as a case manager."

For more information on physical therapists providing workplace injury prevention programs and prevention tips, APTA offers a number of injury prevention brochures such as "Taking Care of your Back" and "What You Need To Know About Carpal Tunnel Syndrome" which explain some of the most common causes of injuries and how to prevent them. For a free copy, send a self-addressed stamped envelope to APTA, P.O. Box 37257, Washington, D.C., 20013.

Secretary's Corner

Plans have been made for OHPTSIG Executive Board members to discuss organizational strategies for 1999. Our annual Board meeting retreat will be held in St. Louis September 11-13, 1998. Just as we solicit you, as the membership, to submit newsletter articles and attend SIG meetings, we also ask your support and input in strategic planning. Your participation will assist our OHPTSIG Board in its mission to define, strengthen, promote, and grow occupational health physical therapy practice across the country. The strategic plan developed at the retreat will be our growth and development "roadmap" for the upcoming year.

If you have thoughts or ideas with regard to tasks, projects, or activities in which the OHPTSIG should be involved, please contact Mark Anderson, OHPTSIG President prior to September 1, 1998. He can be reached at:

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Roberta Kayser, PT
OHPTSIG Secretary and Publications Committee Chair

Ergonomics Task Force Convens at APTA Headquarters

The Occupational Health Special Interest Group continues to spearhead development of a compendium of Occupational Health Guidelines. With the support of the SIG, the Orthopaedic Section and the APTA Board of Directors, the Task Force on Ergonomics Guidelines met in June at APTA headquarters.

Chaired by Mark A. Anderson, MA, PT, CPE of Minneapolis, MN, the task force members are Steven Crandall, PT, OCS of Salt Lake City; Karen S. Piegorsch, MSIE, PT of Columbia, SC; Phil Witt, PhD, PT of Chapel Hill, NC; and Ken Harwood, MA, PT of New York, NY. Allen Wicken, MS, PT is the APTA Staff Liaison.

Charged with developing a set of guidelines that addresses the role physical therapists can play in applying ergonomics principles and concepts in their practices, the group had a rousing two and a half days of discussion. The first draft of the guidelines emerged that delineated three levels of practice involvement: the nonoccupational health PT, the occupational health PT, and the PT who practices ergonomics at a full-time level. A conceptual model was developed that demonstrates the overlap and distinctions of the three levels.

The task force is in the final stages of its first internal review. By the first part of August, the document will be sent out to the SIG membership for review and comment. Once these comments are collated, the group will prepare a final draft for submission to the APTA Board of Directors for review and approval later this year.

The Task Force desires significant feedback from the SIG membership; please invest some time to review the document

when it comes your way. Your involvement is the crucial element of the SIG!

Submitted by;
Mark A. Anderson, MA, PT, CPE
Chairperson, Task Force on Ergonomics Guidelines

Occupational Health Newsbriefs

***Review of Predicting Accident Times*, by James C. Miller & Merrill M. Mitler, from "Ergonomics in Design," vol. 5, no. 4, October 1997**

There are a number of "ergonomic" related questions that may be asked of many of us who provide on-site services. One of these has to do with safety and injury prevention related to shift work and sleepiness. In this article, Miller and Mitler provide an excellent, comprehensible overview of issues related to sleepiness on the job, and associated risks and prevention.

They first give us some background on "circadian rhythms" as a normal, built-in cycle in animals, including humans. Research has shown that "human 'circadian' rhythms in many measures of performance and physiologic activity actually have a two-peak daily pattern." Several studies noted two error-prone "peaks" during work performance of, say, gas company meter readers or vehicle operators. The meter reader error "peaks" occurred between 1:00 and 3:00 AM, and from 1:00 to 3:00 PM. Vehicle crashes peaked between midnight and 6am, and again between 1:00 and 4:00 PM. People have even been found to be more susceptible to diseases or toxins during these peak periods. Summarizing, the authors state that "there are critical periods before dawn and in the middle of the afternoon when sleepiness and inattention may lead to errors that cause industrial incidents and accidents."

So, how can this information be used to prevent work-related injuries? First, the authors say, we must recognize how much more is at stake in today's world if a worker becomes sleepy or loses attention on the job. One example they give is the potential risk of falling asleep driving an 18-wheeler versus a stagecoach. Second, they say, we must recognize that "many jobs and systems have not been designed to use human operators effectively." Systems should be better designed to protect them from "natural human weaknesses, such as vulnerability to attention lapses in boring surroundings." Third, we must accept the reality of a 24-hour work force, and that "night work always compromises a person's ability to get enough sleep."

Prevention, then, must take these factors into account. The authors offer some practical application guidelines to avoid problems related to sleepiness or inattention in the workplace. First, we should use task analysis to identify "safety-sensitive jobs that are most vulnerable to loss of attention." Next, those jobs should be ranked according to their vulnerability to attention lapses and level of risk. The authors recommend that interview and screening methods for new hires "identify and treat or exclude persons with sleep disorders." "Daily patterns of errors of commission, omission and judgment" should be tracked and evaluated. Workers should be educated about management of their sleep and nap times. Shift work jobs should be looked at closely for likely periods of greatest vulnerability, and adjusted accordingly. Safety-sensitive work should be double and triple-checked during periods of vulnerability. Regular (even daily) fitness-for-duty testing can be incorporated for safety-sensitive jobs. The authors even recommend introducing "preplanned naps into the duty periods of selected workers," adapting research conducted on long-haul pilots.

Using some of these simple, basic approaches to recognizing and acknowledging the role of circadian rhythms, we can help companies structure their work to avoid serious accident and injury associated with sleepiness and loss of attention.

Bonnie Sussman, MEd, PT

OCCUPATIONAL HEALTH COMPENDIUM MOVING TOWARD COMPLETION

The OHSIG Practice & Reimbursement Committee, in cooperation with the APTA Department of Practice and the Orthopedic Section office has continued to work toward development of a major resource in Occupational Health Physical Therapy. The "Compendium on Occupational Health Physical Therapy" was conceived at an OHSIG Board Retreat in 1996 as a way to pull together and make available well-designed, professional materials for a variety of "communities" in this growing field. A few of the components of the Compendium are already available through APTA, and the rest are in various stages of development. Following is a list of slated "components" and their status:

Component	Current Status
Definition of Occupational Health Physical Therapy	- completed & approved by APTA BOD and Ortho Section 3/97 - currently available through APTA - possible revisions by technical writer/project manager for final product
Guidelines for PT Management of the Acutely Injured Worker	- completed & approved by APTA BOD and Ortho Section - currently available through APTA - possible revisions by technical writer/project manager for final product
Work Hardening & Work Conditioning Guidelines (AKA "Guidelines for Programs for Injured Workers")	- completed and available for purchase through APTA in booklet form - possible revisions by technical writer/project manager for final product
Functional Capacity Evaluation Guidelines	- completed; approved by APTA BOD 3/98 - possible upcoming publication in Orthopaedic PT Practice - possible revisions by technical writer/project manager for final product
Guidelines for Prevention & Education	- 2nd meeting of Task Force completed APTA in April, 1998 - will be sent out for field review in near future
Guidelines for Ergonomics	- Task Force meeting at APTA planned for Fall, 1998
Risk Management/Legal Issues	- Task Force meeting at APTA planned for late Fall, 1998
Guidelines for Employers (in using OH PT) Guidelines for Payors Reimbursement & Regulatory	- Practice & Reimbursement Committee members to meet in Fall, 1988, to develop

Alan Wicken at the APTA Department of Practice has been highly instrumental in facilitating task forces, field review and revisions, and ushering completed documents through the APTA Board of Directors. The Orthopedic section staff, particularly Tara Fredrickson, will be hard at work on the next phase, that is, trying to bring all these documents into some common format, and helping move the whole Compendium through the publication process. Our goal is to have the full Compendium (with the components as outlined above) available through APTA by the middle of next year.

As with many things like this, we already have the first "revisions" and "additions" under discussion. Ideas for additional components include:

- Consultants Guide
- Education & Training
- Preplacement physical abilities testing
- ADA

We also, of course, will need to build in a schedule for review and update of documents as time passes.

Members of the OHSIG may recall seeing several of these documents come their way for "field review," and that process will continue. However, anyone interested in participating in this process more actively, including possible participation in future Task Forces, please contact Mark Anderson or me.

Bonnie K. Sussman, MEd, PT
Practice & Reimbursement Committee Chair

A Crisis Past

In the 1980s, the US worker's compensation system was failing financially. In the 1990s, costs began coming down and in 1994, after 14 loss years, worker's compensation insurers returned to profitability. This makes worker's compensation the most improved sector of the insurance industry. The most dramatic evidence of this turn around is that worker's compensation premiums have been going down in the past 3 to 4 years with percent of payroll dropping 16% for employers since 1993.

Factors Contributing to the Worker's Compensation Turnaround:

1. Stronger state laws with 32 states enacting laws that classify insurance fraud as a felony.
2. Stronger enforcement in 1998 with 33 states starting special antifraud bureaus and three more establishing legislation to establish such units. Prosecutions for insurance fraud have increased, and the number of insurance companies special investigation units has grown.
3. A safer workplace with average number of workdays lost to job-related injuries declining nearly 18% 1992-1996, according to U.S. Bureau of Labor Statisitcs data.
4. Managed where employers and medical providers aggressively utilize case management to monitor individual claims and efforts are made to accelerate an injured worker's safe return to work.
5. Public attitudes have changed as a result of massive advertising and education campaigns by the insurance companies raising public awareness about the impact of fraud.

Worker's Compensation Fraud: What You Can Do

Business owners need to protect themselves against worker's compensation fraud by taking pro-active preventative measures, recognizing suspicious cases, and helping insurers combat the problem by providing information about fraud activities.

Preventing Fraud

1. Maintain a safe workplace.
2. Screen job applicants.
3. Give all new hires a copy of your company's worker's compensation policies and a separate written statement about safety expectations.
4. Be wary of unknown or cut rate insurers when switching to a new carrier.
5. Be honest with your insurance agent to prevent premium fraud.

Recognizing Fraud

Fraud MAY be present when....

1. the accident occurs late Friday or early Monday morning.
2. no one saw the injury occur.
3. the accident occurred outside the employee's regular work area.
4. the reported incident occurs just before or after a strike.
5. the claimant's description conflicts with that in the initial written report.
6. the employee delays reporting the claim with no reasonable explanation.
7. the employee has a history of numerous suspicious or litigated claims.
8. a diagnosis is inconsistent with treatment or time off for the injury is excessive.
9. the claimant refuses diagnostics to confirm the nature of the injury.
10. a claimant is hard to reach at home or changes residences, jobs, or physicians frequently.

Strategies to Fight Worker's Compensations Fraud

1. Document everything.
2. Keep your eyes and ears open.
3. Communicate regularly.

Submitted by Mark Kerestan, PT
Nation's Business, published by the
U.S. Department of Commerce, April 1998.

FOOT & ANKLE

SPECIAL INTEREST GROUP
ORTHOPAEDIC SECTION, APTA, INC.

CHAIRS REPORT

Since assuming the position of FASIG chair, I am continually amazed by the amount of work performed by our various committees throughout the year.

My amazement is surpassed only by the numbers of these projects which actually come to fruition as a result of the hard work and dedication by our committee members.

One such project, previously discussed at the CSM meeting in Boston '97, involved a joint proposal between FASIG and the AOFAS (American Orthopedic Foot and Ankle Society). This proposal has not only been endorsed by the Orthopedic Section but has received funding approval from the section. The objectives of this proposal are as follows:

- Appointment of the FASIG Chair as the liaison to the AOFAS.
- Exchange attendance of liaisons at our national meetings.
- Exchange the annual meetings of FASIG and the AOFAS.

A second proposal involved the organization of a research retreat, in order to bring research and clinical pathways closer together in the area of foot and lower extremety. Irene McClay and Debbie Nawaczenski have been hard at work coordinating this effort.

The symposium will be entitled "From the Research Lab to the Clinical Arena." It will be held in May 1999 in the Finger Lakes region of Rochester, New York. (Stay tuned for more details.) Keep in mind that Finger Lakes is wine country.

Mark Cornwall has been working diligently on the upcoming itinerary for the FASIG educational meeting at CSM Seattle, 1999.

The topics and list of speakers are as follows:

SPEAKER/TOPIC

1. Brian Pease, PT
   Management of Hallux Limitus and Rigidus
2. Nancy Henderson, PT, PHO, OCS
   Measuring Function Outcomes for the Foot
3. Rob Martin, PT
   Conservative and Surgical Management of Ankle Arthritis
4. Jim Birke, PT, PhD
   Foot Orthotic Materials What, Whys, When
5. Mark Cornwall, PhD, PT
   Topic – to be announced

On a more serious note, it has come to my attention that at least three states have passed a bill in the legislature requiring licensure to utilize prosthetics and orthotics.

The general thrust of such a bill implies that those who wish to practice and employ the use of orthotics and prosthetics must be certified by the American Board for Certification in Orthotics and Prosthetics.

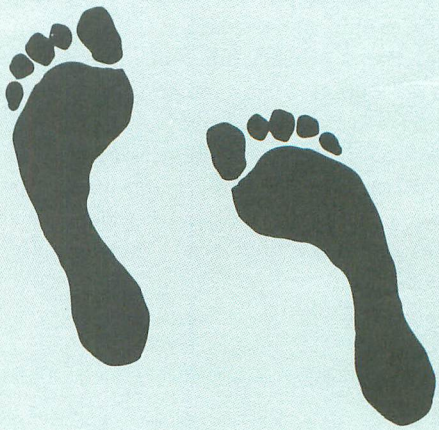
I believe it is imperative that we, as physical therapists who utilize orthotics and prosthetics as a significant part of our practice, do not allow such legislation to interfere with our ability to practice skills which we are so highly qualified to perform.

I have contacted Dorothy Santi who is coordinating efforts with the Practice Committee in an attempt to address these critical issues. If anyone would like more information regarding this bill, please feel free to contact me at your convenience at e-mail: Stephenb.@helix.org. (410) 583-9980.

Finally, I would like to thank Debbie Nawoczenski for submitting a synopsis of her lecture presented at CSM in Boston, to *OP* this quarter. The article is entitled "First Metatarsophalangeal Joint Kinematics and Clinical Measurements."

I look forward to meeting with all of you in Seattle at CSM.

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



First Metatarsophalangeal Joint Kinematics and Clinical Measurements

Deborah A. Nawoczenski, PhD, PT
Judith F. Baumbauer, MD
Ithaca College – University of Rochester Campus and the Department of Orthopaedics, University of Rochester. Rochester, New York.

The importance of the first metatarsophalangeal joint (MTP) has long been recognized in the proper function of the foot during gait. A critical component of normal ambulation is the achievement of adequate great toe motion, specifically in the direction of dorsiflexion, during terminal stance and preswing phases of gait. Restrictions in the amount of first MTP motion, such as encountered with hallux rigidus deformity, can result in pain, prominent osteophyte formation, and progressive limitation of dorsiflexion. Gait patterns may be altered as the patient's weight-bearing forces shift laterally to compensate for limitation of dorsiflexion at the MTP joint. In addition to the functional limitations related to pathology of the first MTP, there is significant economic impact associated with orthotics, shoe modifications, and surgical procedures designed to decrease pain through modifications in first MTP joint motion.

Clinical measurements of first MTP motion are used to guide both nonsurgical and surgical treatment approaches. These measurements also comprise a major component of clinical rating scales used to indicate foot function. What is confusing is the considerable variability reported in the literature for normative values for static tests of first MTP motion, and for first MTP motion during gait. Maximum range-of-motion (ROM) has been reported to range between 65° and 110° for dorsiflexion, and between 20° and 45° for plantarflexion. Similar variability has been reported for first MTP motion during gait, with values ranging between 50° and 90° of dorsiflexion.

A number of factors may account for the variability among investigations of first MTP motion. They include: differences in description of the joint "zero" or neutral position; the weight-bearing status of the person being measured; assessment of active versus passive motion; and the instrumentation and/or methods used to acquire the data. What becomes apparent upon examination of the literature is the need for a reliable and valid clinical test that will aid in standardizing reporting techniques and improve the clinician's ability to interpret clinical outcomes.

Although it is of primary functional interest, measurement of first MTP motion during dynamic activities is difficult. Clinicians frequently rely on relatively static clinical tests to estimate motion of the first MTP during gait, although the relationship between the clinical measurements and MTP motion during gait is not well understood. We recently examined the relationship between four commonly used clinical tests of first MTP motion, and motion of this joint during gait. The Flock of Birds™ electromagnetic tracking device was used to acquire 3D orientation data of the hallux with respect to the first metatarsal using receivers secured to the skin overlying the proximal phalanx of the hallux, first metatarsal, and calamus. The four clinical tests assessed were: active ROM, weight-bearing (AROM-WB); passive ROM, weight-bearing (PROM-WB); passive ROM, nonweight-bearing (PROM-NWB); and a heal rise test (HR). Data were also collected as the subjects walked within the range of the transmitter. Due to the nature of MTP motion during gait, statistical analyses were restricted to the dorsiflexion component of rotation.

With the exception of PROM-NWB and HR, all clinical tests were significantly different from each other. We also found that the full expanse of motion available in the clinical tests was not utilized during gait. That is, the clinical tests either equaled or exceeded the motion requirements of the first MTP in gait. The HR and AROM-WB tests demonstrated the strongest correlation to MTP motion in gait ($r = .87$ and $r = .80$, respectively). The mean value for AROM-WB (44°) more closely approximated the mean value for walking (42°) than did the HR test (58°).

The findings of this study emphasize the need to be consistent with assessment and documentation of the clinical measurement chosen for first MTP motion, particularly in follow-up or repeated motion assessment. The selection of the test may positively or negatively impact outcome scores that utilize ROM measurements as predictors of foot function.

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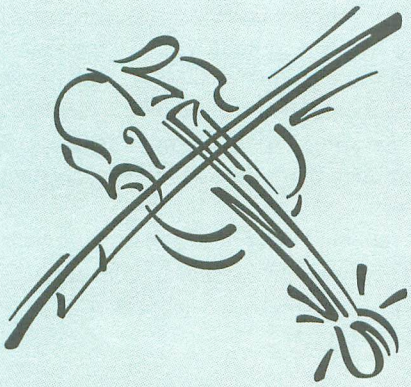
Deborah A. Nawoczenski PhD, and Judith F. Baumbauer, MD Ithaca College – University of Rochester Campus and the Department of Orthopaedics, University of Rochester. Rochester, New York.



Performing Arts

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

PERFORMING ARTS SIG

The Performing Arts Special Interest Group is planning another series of engaging and informative educational programs for February 1999. The group is planning two informal morning roundtable discussions. The topics will be as follows:

Roundtable One: "Becoming a Performing Arts Mentor." This is a panel discussion in fostering mentorship as well as developing guidelines for internships and residencies in the field of performing arts physical therapy.

Roundtable Two: "Getting Your Research Started." This is a panel discussion designed to help the clinician develop specific research questions, proposals, and designs in the area of performing arts.

There are three hours of joint programming planned with Occupational Health SIG. The topics include:

1. "Ergonomic Solutions for the Injured Musician." Lori Stotko OTR, CHT will discuss various instrumental adaptations and splinting interventions.
2. "CTD Prevention: Creating and Selling a Program." Mary Davenport PT, OCS will discuss how to access a performing arts organization and how to market a program of physical therapy, based on industrial medicine models.
3. "Psychosocial Aspects of the Workplace: Issues Around Performance." Linda Hamilton PhD will discuss the psychosocial issues faced by performing artists and industrial workers.

This should be an exciting and stimulating program. We invite all individuals interested in performing arts and industrial medicine to attend.

Nick Quarrier PT, OCS; PASIG Vice President and Program Chair

PASIG Membership Directory and Mentorship Questionnaire

Thanks to our members who returned our somewhat lengthy questionnaire. Out of a mailing of 235, 77 were returned (a 33% return rate). The Orthopaedic Section tells us this is a phenomenal return rate! But there's still time... The Mentorship Task Force is reaching out to contact performing arts individuals and institutions who are not currently members. We want to know all PTs working in this area. They may not know about us, and may provide valuable liaisons for the PASIG as well as performing artists. So, if you know about groups or individuals who we should contact, let us know. And the 158 of you who didn't respond: get it together and send it in. If you did not receive a questionnaire, call Tara at the Orthopaedic Section office and she'll get one out to you.

Shaw Bronner PT, OCS; PASIG Secretary
Donna Ritter Mentorship Task Force Chair

PR and Media Liaison Task Force

Jeff Stenback and his committee are working hard on developing a PASIG brochure. We hope to use this as an educational tool for the general public to educate them about who we are and what we can do as performing arts physical therapists. He still needs black and white photographs - please let him know if you have something that might work. The completed product should be ready at the Seattle CSM.

PASIG Membership News

Congratulations to Nick Quarrier and Ithaca College who recently hosted: "The Healthy Musician: Injury Prevention and Intervention." Nick reports the workshop for health care providers consisted of three days of seminars examining the mental and physical factors that affect musicians and their performance. Areas of instruction included physiology, posture, neuromuscular re-education, mental training, practice techniques, physical therapy treatment strategies, neural-lingual programming (NLP), splinting, biofeedback, and stress management. Major instrument families were introduced and demonstrated by college music professors. Various therapeutic treatment interventions were demonstrated on the musicians. The music faculty performed a mini-recital to help demonstrate performance.

Twenty five individuals from many parts of the country attended the program. The majority were physical therapists and professional musicians. There were also occupational therapists and a physician. The mix of health care workers and musicians added a valuable aspect to the program. Individuals exchanged dialogue and provided varied insights into the field of performing arts medicine. By observing musical performance up close, the therapists were able to

examine the biomechanics and technicalities of playing various musical instruments.

With the growing interest in the field of performing arts medicine, it is becoming increasingly important for therapists to network and provide affiliations and mentorships in this specialty area.

Treatment strategies must be examined, and research into the cause of music-related injuries is greatly needed. It is hoped the PASIG will attract more therapists and address these issues.

The 8th Annual International Association of Dance Medicine and Science (IADMS) conference takes place October 29-31, in Hartford, CT. PASIG Secretary Shaw Bronner will be presenting a kinematic profile of the pass (in healthy elite dancers), and participating on a panel on dance medicine research issues. Her topic will be dance epidemiology - working towards a standardized methodology for defining and analyzing dance injuries.

Listed below are proposed amendments to the PASIG Bylaws. These proposed amendments have previously been approved by the Section's Board of Directors, and we are now publishing them for review by the PASIG membership. These proposed amendments will appear again in the PASIG election ballot. The new items being proposed are shown as underlined, and the proposed deletions are shown with ~~a line running through~~ them.

PROPOSED AMENDMENTS

Under: ARTICLE II. Purpose

The ~~purpose~~ purposes of the PASIG is are: 1) to provide a forum where individuals having a common interest in ~~Performing Arts Physical Therapy~~ physical therapy for the performing artist may meet, confer, and promote patient care through education, clinical practice, and research; 2) to increase public awareness of the unique role of physical therapists in treating performing artists; and 3) to provide a referral source for community organizations, educational institutions, performing arts organizations, other health care professionals, and all other physical therapists in our Association.

Under: ARTICLE III. Objectives

3. Identify the unique role of physical therapists in ~~Performing Arts Physical Therapy~~ the treatment of the performing artist.

4. Provide a forum for exchange and dissemination of information about current trends and practices specifically related to ~~Performing Arts Physical Therapy~~ physical therapy for the performing artist particularly rehabilitation and education.

6. Develop and recommend practice standards and practice terminology for therapists involved in ~~the practice of Performing Arts Physical Therapy~~ treating performing artists.

7. Identify resource people and materials to ~~accurately~~ share practice information and address areas of concern related to ~~Performing Arts Physical Therapy~~ physical therapy for the performing artist ~~with the guidance of the Section.~~

8. Identify changes in state and national legislation, regulation and reimbursement issues affecting the practice of ~~Performing Arts Physical Therapy~~ physical therapy for the performing artist and disseminate that information to interested PASIG members.

9. Foster valid and reliable research in the area of ~~Performing Arts Physical Therapy~~ physical therapy for the performing artist and submit annual and other requested reports to the Section Board of Directors.

Under: ARTICLE V: Meetings

Section 1: A minimum of two (2) meetings of the PASIG membership shall be held annually. One (1) shall be in connection with an educational program related to ~~Performing Arts Physical Therapy~~ physical therapy for the performing artist.

CALL FOR NOMINATIONS

President
Treasurer
1 Nominating Committee Member
Deadline for nomination submissions: October 5, 1998
Send nomination information to:

Donna Ritter, PT
6314 Bandera Ave., Apt. B
Dallas, TX 75225
Pager/Voice Mail: 214/892-0049

PASIG Executive Board

President: Brent Anderson PT, OCS phone: (305) 529-0023 fax: (305) 284-4534 e-mail: brentlizet@ shadow.net

Vice President: Nick Quarrier PT, OCS phone: (607) 274-3053 fax: (607) 274-1137 e-mail: nquarrie@ithaca.edu

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

Pain MANAGEMENT

SPECIAL INTEREST GROUP • ORTHOPAEDIC SECTION, APTA, INC.

From the PMSIG Newsletter Editor

My name is Lisa Janice Cohen, and I am the new editor of the PMSIG newsletter. I hope you share my excitement about the potential of this publication and of this special interest group. Pain spans all diagnoses and patient classifications. All physical therapists need to be skilled at assessing pain and managing pain. Some of the purposes of this PMSIG are to share strategies for pain management, explore the relevant research, and to network with other clinicians who have an interest in pain management.

I invite you to participate in this newsletter by submitting letters, case studies, position papers, abstracts from the literature, or resources for your fellow clinicians. For your convenience, my e-mail address and FAX number are listed below. I look forward to hearing from you!

Lisa Janice Cohen, MS, PT, OCS
cohen.lisa@mgh.harvard.edu
fax: 617-726-8022

Call for Nominations

The terms of office for all the PMSIG positions are 2 years. Elections are staggered with the President and Secretary alternating with the Vice President. The Nominating Committee is seeking names of individuals willing to be nominated for the offices of President and Secretary. Elections will be held at the PMSIG business meeting at CSM '99 in Seattle, WA. All orthopaedic section members are eligible to vote. ***Nominees must be members of the Orthopaedic Section.***

Please contact either Lisa Cohen (617-724-6306) or Joe Kleinkort (indusrehab@aol.com).

CONTENTS:

Current Officers: PMSIG

Tom Watson, MEd, PT, FAAPM
President
Joe Kleinkort, MA, PhD, PT
Vice President
John E. Garzione, PT, AAPM
Secretary

President's Message

Welcome to the PMSIG newsletter. This is our 3rd year and we're excited about this newsletter, 1999 CSM and our future. Thank you to the Orthopaedic Section for all its help. There are many new, innovative, controversial and unique qpproaches to the treatment and management of pain. Knowledge in this field seems to double every 2 or 3 years and its difficult to stay abreast of these changes. We hope this newsletter will afford you one avenue of learning and if you're inclined, sharing your knowledge. We would also appreciate your input on the board certification process of physical therapists in pain management by the ABPTS. We are moving rapidly in this direction. Please give your feedback directly to the Orthopaedic Section.

If you have questions for me please don't hesitate to contact me at 760-796-6789 or painfree@ix.netcom.com

Thank you for your interest in pain.
Tom Watson MEd PT FAAPM

Secretary's Corner

As secretary of the PMSIG, I would like to welcome you to the "first" newsletter. The SIG has evolved after many years of infancy and matured into a significant special interest group. Thank you to all who were involved with this process and to those who are still working diligently to finalize our mission statement.

An excerpt from the "Pain Net News" vol 5, no. 2 attracted my attention since it impacts our practice. The article alerts all practitioners of the legal ramifications of obtaining and using any medical equipment on a patient that has not been issued a 510K and market release by the FDA. HCFA will impose significant fines and possible jail time on practitioners who use questionable devices on their patients. It is up to the therapist to insure that his or her equipment has an FDA release to use on humans, as well as its indications prior to usage. This is especially important with the new technologies that are evolving rapidly and the plethora of new devices. (As if we don't have enough to think about already.)

Interesting too are the preliminary findings reported in the American Journal of Pain Management, vol 8, #2, April 1998. They report significantly lower blood seratonin levels in most patients with chronic pain.

I hope to be able to meet many of you at the CSM 1999 at our SIG meeting.

Have a great autumn.
John E Garzione, PT, AAPM

Manual Treatment of Pelvic Dysfunction in a Geriatric Patient Status/Post Hip Fracture and Hip Replacement: A Case Study

Gaetano G. Scotece, MPT, FAAPM; Donna Perry, PT; Katherine Thermann, PT (Lakewood Healthcare Center, A Vencor Facility, Lakewood, WA)

AH is an 82 yo female who sustained a right hip fracture after falling in her home. She received emergency care including x-rays, sedation, and surgery (uncemented prosthesis). On postop day 3, she was transferred to a skilled nursing facility (SNF) for subacute rehabilitation.

Prior history:

Prior to her fall, AH had lived at home with her 84 yo spouse. AH was an independent community ambulator and drove her car. She was an active volunteer and participated in ballroom dancing.

AH was referred to physical therapy with orders for touch-down weight bearing X 6 weeks with hip precautions.

Initial Evaluation:

Function (via FIM scores): bed mobility-mod assist (3.0)
transfers—mod assist (3.0)
gait—max assist (2.0) w/wheeled walker
Strength R hip: flexion 1+/5, extension 2/5, abduction 2/5, ext. rotation 2/5, adduction & int. rotation n/a.
Pain: 9/10, unmedicated, 4/10 medicated.

Treatment:

Progress was as expected for the first 6 weeks, with increasing strength and function, decreased pain (2-3/10 with 2 Percocet prn). On week 7, AH was progressed to full weight bearing. Her pain (right hip/SI area) increased markedly (7-8/10, 8 Percocets/day). She complained of feeling her right lower extremity (RLE) was "too long" and refused to weight bear or ambulate. X-rays were negative for fracture or dislocation. PT re-evaluation revealed 1 inch shortening of the nonsurgical (left) side with elevated left ASIS, left PSIS, left pubis and left IT. AH underwent manual therapy treatment (muscle energy tech) for "up slip" left correction with SI joint stabilization exercises twice/day X 4 days.

Results:

Pain 2/10 w/Tylenol prn. Functional levels increased steadily over the next 2 weeks to a FIM level of 6.0-7.0 in all areas. AH was discharged to home. Follow-up phone call revealed she was functioning independently with wheeled walker.

Conclusion:

Manual therapy evaluation and treatment appears to be an efficient and effective tool to facilitate the rehab of an elderly patient s/p hip replacement surgery. Timely intervention by the manual therapist in this case facilitated improved function, decreased pain medication usage, and discharge to home.

Justifying Aquatic Physical Therapy in a Warm Water Pool for Patients with Chronic Pain

Simone L. Palmer, PT (Massabesic Health Recourses, P.A., Waterboro, ME)

Common Problems Associated with Chronic Pain

1. Decreased cardiovascular fitness
2. Decreased joint mobility & soft tissue extensibility
3. Muscle weakness
4. Sympathetic response amplification
5. Multiple subjective pain complaints
6. Psychosocial challenges including depression and isolation
7. Reduced mental status
8. Disturbed sleep patterns
9. Obesity
10. Gait and balance disorders

Treatment Goals

1. Increase cardiovascular fitness
2. Increase joint mobility and soft tissue extensibility
3. Address muscle weakness
4. Reduce overactivity of sympathetic nervous system
5. Reduce intensity of subjective pain complaints
6. Provide a positive environment for behavioral change
7. Engage in mental activities to stimulate processes and increase patient's responsibility for own wellness
8. Incorporate relaxation training into program
9. Provide safe environment to participate in an appropriate exercise program
10. Provide safe environment for gait/balance training which minimizes risks of re-injury

Treatment Methods

1. Initiate PT examination as per the *Guide to Physical Therapist Practice*
2. Design a patient specific aquatic therapeutic exercise regimen to address the unique pathology & presentation of each patient
3. Direct treatment toward maximizing patient self management, including planning for postdischarge program
4. Accompany patient into the pool to provide thorough 1:1 professional care and individualized instruction

Treatment Precautions and Modifications

1. Precautions to aquatic intervention are acknowledged by the PT and patient. Specific needs are met by PT and facility staff to provide safe environment.
2. PT begins each session reviewing program and status with each patient, noting changes as necessary.
3. Treatment is modified as necessary to optimize benefit of aquatic intervention.

Justification of the Benefits of Aquatic Interventions in Contrast with Land Interventions

Ideally, review of the literature would provide examples of evidence-based practice to support the scientific basis for aquatic intervention with the patient with chronic pain. The Aquatic Resources Network has published the AquaBulletsTM Literature summaries, which outline current aquatic therapy practices. In future issues I will present an in-depth article with scientific justification to support the use of aquatic intervention in the patient with chronic pain.

Pain Resources for Clinicians

The American Pain Society (APS)—a multidisciplinary organization dedicated to serving people in pain, a national chapter of the International Association for the Study of Pain (IASP).

http://www.ampainsoc.org
APS 4700 W Lake Ave
Glenview, IL 60025
847/375-4715

The International Association of the Study of Pain (IASP) is an international, multidisciplinary, nonprofit professional association dedicated to furthering research on pain and improving the care of patients with pain. Currently IASP has 6300 individual members from 86 countries.

http://www.halcyon.com/iasp
IASP Secretariat
909 NE 43rd St., Suite 306
Seattle, WA 98105-6020
206/547-6409

The American Academy of Pain Management(AAPM) is the largest multidisciplinary pain society and largest physician based pain society in the United States. The Academy is a nonprofit multidisciplinary credentialing society providing credentialing to practitioners in the area of pain management.

http://www.aapainmanage.org
13947 Mono Way A
Sonora, CA 95370
209/533-9744

Pain Research & Management
Official Journal of the Canadian Pain Society

http://www.pulsus.com/pain/home.htm

Please share relevant pain related resources with your fellow clinicians. I will attempt to make this column a regular feature of our newsletter.

PROPOSED PEER REVIEW LEGAL PRACTICE SPECIAL INTEREST GROUP, ORTHOPAEDIC SECTION, APTA

Do you perform or have an interest in peer review and expert testimony? Do you have an interest in fraud and abuse prevention/prosecution? Do you have an interest in the regulatory aspect of physical therapy practice? Then this proposed Special Interest Group (SIG) is for you!

We are Orthopaedic Section members who are interested in starting a SIG. We envision the mission of the SIG will be to meet your and our educational needs in this subspecialty area of practice. The SIG will provide networking opportunities with peers of a common interest and promote peer review by physical therapists. It will provide a resource for APTA members and the Association's leadership with peer review, legal, and regulatory questions/issues. The SIG will also establish a directory of members who are interested in being retained in the areas of peer review, legal/regulatory consultation, and expert opinions/testimony.

This is our initial communication with the Orthopaedic Section membership and our first priority is to get a sense of the level of interest in the concept of a Peer Review Legal Practice SIG. We are open to further refinement or expansion of the proposed mission of the SIG. Therefore, if you have any ideas or suggestions please let us know your thoughts.

We have asked the Orthopaedic Section for meeting space at the 1999 Combined Sections Meeting. Watch for details. At that time, we hope to have enough Section members who have signed the petition so that we can submit it to the Board of Directors of the Orthopaedic Section.

To become a Level I SIG we need to have at least 200 signatures from Orthopaedic Section members on our petition. If you are interested, please complete the form below. The sooner we have enough signatures the sooner we can get the ball rolling. So don't wait, fill out and send in the form below.

For Questions or Comments Please Contact:

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☐ Yes I am in favor of this group forming.

Name _____

Address _____

City _____ State _____ Zip _____

APTA ID # _____

Signature _____

Please Fax to 608/788-3965

Veterinary

SPECIAL INTEREST GROUP

Orthopaedic Section, APTA, Inc.

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GOALS

The goals of the Veterinary Physical Therapy Special Interest Group are similar to other special interest groups within the APTA. It is important for physical therapists with a common interest to be able to explore new fields of practice and have a forum for sharing information.

1. To promote physical therapy
2. To share information
3. To collaborate with other health professionals
4. To develop educational programs
5. To foster research
6. To create guidelines for practice
7. To encourage appropriate legislative changes
8. To establish a national network
9. To protect professional practice

NATIONAL GUIDELINES OF APTA AND AVMA

PREAMBLE

Veterinary medicine like all professions, is undergoing changes with increasing rapidity. Additional modalities of diagnosis and therapy are emerging in veterinary and human medicine. These guidelines reflect the current status of the role of these emerging modalities within the parameters of veterinary medicine for use in providing a comprehensive approach to the health care of nonhuman animals.

Use of these modalities is considered to constitute the practice of veterinary medicine. Any exceptions will be indicated in the following guidelines. Such modalities should be offered in the context of a valid veterinarian/client/patient relationship. It is recommended that appropriate client consent be obtained. Educational programs are available for many of the modalities. It is incumbent upon veterinarians to pursue education in their proper use.

It should be borne in mind that because the emergence and development of these modalities is a dynamic process, as time passes, the following information may need to be modified.

VETERINARY ACUPUNCTURE AND ACUTHERAPY

Veterinary acupuncture and acutherapy involve the examination and stimulation of specific points on the body of nonhuman animals by use of acupuncture needles, moxibustion, injections, low-level lasers, magnets, and a variety of other techniques for the diagnosis and treatment of numerous conditions in animals.

Veterinary acupuncture and acutherapy are now considered an integral part of veterinary medicine. These techniques should be regarded as surgical and/or medical procedures under state veterinary practice acts. It is recommended that educational programs be undertaken by veterinarians before they are considered competent to practice veterinary acupuncture.

VETERINARY CHIROPRACTIC

Veterinary chiropractic is the examination, diagnosis, and treatment of nonhuman animals through manipulation and adjustments of specific joints and cranial sutures. The term "veterinary chiropractic" should not be interpreted to include dispensing medication, performing surgery, injecting medications, recommending supplments, or replacing traditional veterinary care.

While sufficient research exists documenting efficacy of chiropractic in humans, research in veterinary chiropractic is limited. Sufficient clinical and anecdotal evidence exits to indicate that veterinary chiropractic can be beneficial. It is recommended that further research be conducted in veterinary chiropractic to evaluate efficacy, indications, and limitations. The assurance of education in veterinary chiropractic is central to the ability of the veterinary profession to provide this service.

Veterinary chiropractice should be performed by licensed veterinarians; however, at this time, some areas of the country do not have an adequate supply of veterinarians educated in veterinary chiropractic. Therefore, it is recommended that, where the state's practice acts permit, licensed chiropractors educated in veterinary chiropractic be allowed to practice this modality under the supervision of, or referral by a licensed veterinarian who is providing concurrent care.

VETERINARY PHYSICAL THERAPY

Veterinary physical therapy is the use of noninvasive techniques, excluding veterinary chiropractic, for the rehabilitation of injuries in nonhuman animals. Veterinary physical therapy performed by nonveterinarians should be limited to the use of stretching, massage therapy, stimulation by use of a) low-level lasers, b) electrical sources, c) magnetic fields, and d) ultrasound, rehabilitative exercises, hydrotherapy, and applications of heat and cold.

Veterinary physical therapy should be performed by a licensed veterinarian or, where in accordance with state practice acts, by 1) a licensed, certified, or registered veterinary or animal health technician educated in veterinary physical therapy or 2) a licensed physical therapist educated in nonhuman animal anatomy and physiology. Veterinary physical therapy performed by a nonveterinarian should be performed under the supervision of, or referral by, a licensed veterinarian who is providing concurrent care.

MASSAGE THERAPY

Massage therapy is a technique in which the persons uses only their hands and body to massage soft tissues. Massage therapy on nonhuman animals should be performed by a licensed veterinarian with education in massage therapy or, where in accordance with state veterinary practice acts, by a graduate of an accredited massage school who has been educted in nonhuman animal massage therapy. When performed by a nonveterinarian, massage therapy should be performed under the supervision of, or referral by, a licensed veterinarian who is providing concurrent care.

VETERINARY HOMEOPATHY

Veterinary homeopathy is a medical discipline in which conditions in nonhuman animals are treated by the administration of substances that are capable of producing clinical signs in healthy animals similar to those of the animal to be treated. These substances are used therapeutically in minute doses.

Research in veterinary homeopathy is limited. Clinical and anecdotal evidence exists to indicate that veterinary homeopathy may be beneficial. It is recommended that further research be conducted in veterinary homeopathy to evaluate efficacy, indications, and limitations.

Since some of these substances may be toxic when used at inappropriate doses, it is imperative that veterinary homeopathy be practiced only by licensed veterinarians who have been educated in veterinary homeopathy.

VETERINARY BOTANICAL MEDICINE

Veterinary botanical medicine is the use of plants and plant derivatives as therapeutic agents. It is recommended that continued research and education be conducted. Since some of these botanicals may be toxic when used at inappropriate doses, it is imperative that veterinary botanical medicine be practiced only by licensed veterinarians who have been educated in veterinary botanical medicine. Communication on the use of these compounds within the context of a valid veterinarian/client/patient relationship is important.

NUTRACEUTICAL MEDICINE

Nutraceutical medicine is the use of micronutrients, macronutrients, and other nutritional supplements as therapeutic agents.

HOLISTIC VETERINARY MEDICINE

Holistic veterinary medicine is a comprehensive approach to health care employing alternative and conventional diagnostic and therapeutic modalities.

In practice, holistic veterinary medicine incorporates, but is not limited to, the principles of acupuncture and acutherapy, botanical medicine, chiropractic, homeopathy, massage therapy, nutraceuticals, and physical therapy as well as conventional medicine, surgery, and dentistry. It is recommended that holistic veterinary medicine be practiced only by licensed veterinarians educated in the modalities employed.

The modalities comprising holistic veterinary medicine should be practiced according to the licensure and referral requirements concerning each modality.

APTA House of Delegates POSITION ON PHYSICAL THERAPISTS IN COLLABORATIVE RELATIONSHIPS WITH VETERINARIANS. HOD 06-93-20-36 (Program 32)

The American Physical Therapy Association (APTA) endorses the position that physical therapists may establish collaborative, collegial relationships with veterinarians for the purposes of providing physical therapy services or consultation.

"Physical therapists are the provider of choice for the provision of physical therapy services regardless of the client. A collegial relationship is advantageous to the client."

GUIDELINES FOR CERTIFICATION IN VETERINARY PHYSICAL THERAPY

The following guidelines are provided for your information and review. This is a "working" document and will be revised as needed. Please forward your comments to David Levine, PT (david-levine@utc.edu).

1. General

The guidelines outlined in this document are a proposal for certification of physical therapists who wish to collaborate with veterinarians. The certification process would ensure that physical therapists had an appropriate level of knowledge in the field of veterinary medicine. Physical therapist assistants and athletic trainers would not be certified under this process. Veterinarians and veterinary technicians are welcome to take courses that are provided to support the

certification process. The AVMA would administer their certification if that is desired. Legally, it is not necessary for veterinarians or veterinary technicians to be certified to perform physical therapy techniques on animals. However, it would be beneficial for veterinarians and veterinary technicians to become educated and develop clinical skills prior to integrating physical therapy evaluation and treatment techniques into their practice.

The intent of veterinary physical therapy would be to complement rather than replace traditional veterinary medicine. Physical therapists would follow national AVMA and APTA guidelines that address veterinary physical therapy Physical therapists would also be responsible for following their state practice act, which may or may not limit licensed physical therapists to working with human clients.

Applicants must hold a current license to practice physical therapy in the United States, and have practiced in the field of human physical therapy for at least two years.

2. Course work

A minimum of 115 hours in classroom instruction (a limited number of hours may be allowed through homestudy courses) that has been approved by the Orthopaedic Section of the APTA is required.

- Mandatory instruction is required in each of the following areas. The minimum number of hours required in each area is listed in parenthesis.
- Introduction to veterinary physical therapy (history, legal issues, insurance issues, etc.) (2)
- Introduction to veterinary medicine/terminology (3)
- Anatomy and physiology of domestic animals including changes throughout the life cycle (32)
- Biomechanics (range of motion, gait) (8)
- Animal behavior/safety/handling/legal issues (5)
- Pathophysiology of the musculoskeletal system (common conditions, surgical procedures, etc.) (10)
- Pathophysiology of the nervous system (6)
- Pharmacology (5)
- Basic evaluation of domestic animals (taking a history, subjective signs, objective data such as range of motion, function, strength, integrity of the nervous system, documentation, etc.) (10)
- Treatment including modalities, functional training, joint mobilization, aquatic therapy, home program instruction and documentation (20)
- Adaptive equipment (5)
- Gait analysis (5)
- How to write/document a case study (3)

Courses may include required pre-instructional studies such as anatomy review, readings, or other work deemed appropriate. Courses may also require postcourse completion of didactic or clinical work to receive CEUs.

3. Clinical Requirements

A minimum of 120 contact hours in clinical practice is required with a minimum of 80 hours being required under the direct supervision of a licensed veterinarian, and a minimum of 40 hours under the direct supervision of a certified veterinary physical therapist. These hours must be documented on the appropriate forms, signed by the supervising veterinarian(s) and physical therapist(s), and notarized. Clinical hours must have been obtained within the last 3 years prior to application.

A minimum of five case reports of individual cases of animals that the applicant has worked with must also be submitted in the appropriate format to document progression and competency. These cases are to document the efficacy and effectiveness of physical therapy intervention in the field of veterinary medicine, and are a significant aspect of the certification process. Cases will be reviewed by the examining committee.

Certification Examination

A written examination prepared by licensed veterinarians and physical therapists will be administered once the applicant has successfully completed the coursework and clinical requirements.

Continuing Certification Requirements

Individuals certified in veterinary physical therapy will be required to submit documentation of 20 CEUs every two years in courses approved by the veterinary special interest group of the Orthopaedic Section, American Physical Therapy Association.

Veterinary Physical Therapy Education Plan

Our plan is to create a curriculum to support the certification process. In response to feedback from therapists we have separated our courses into three specialty areas: canine, equine and wildlife/exotic/farm animals. We plan to establish 4 to 5 education centers across the country linked to veterinary and physical therapy colleges ie, NY, TN, CO, CA, NC. A series of up to seven courses would be provided over a period of two years for each area of interest. The format of the basic classes would include lecture, laboratory sessions, and demonstrations. Advanced topics would be optional and will be provided when sufficient numbers of therapists or veterinarians register for the classes. As an example I have included the proposal for the Canine Education Plan. Please remember, the curriculum is still in the development stage. We welcome your input and suggestions. The Equine and Wildlife Education Plans will be printed in upcoming issues of this newsletter.

Canine Education Plan

Courses:

Canine Physical Therapy I - Introductory Course - 2 1/2 DAYS with Demonstrations
Canine Anatomy/ Physiology - 4 DAYS
Canine Biomechanics and Gait- 3 DAYS
Canine Musculoskeletal Dysfunction, Surgical Procedures, and Geriatrics- 4 DAYS
Canine Behavior, Safety and Handling - 2 DAYS
Canine Physical Therapy Evaluation, Treatment and Functional Training - 5 DAYS

Veterinary Pharmacology and Terminology (Home Study)

Basic Topics:

Anatomy and Physiology	Biomechanics
Evaluation	Surgical Procedures
Safety and Handling	Behavior
Functional Training	Musculoskeletal Dysfunction
Treatment	Home Programs
Pharmacology	Geriatrics
Orthotics/Prosthetics	Adaptive Equipment

Laboratory Sessions:

Anatomy Dissection
Gait Evaluation
Handling and Restraint

Demonstrations:

Performance Center with Treadmill or Pool
Working Dogs: Guiding Eyes, Rescue, and Driving - Sled Dogs, Jumping and Agility, Circus
Orthopedic/Neurological Surgery

Advanced Topics:

Accupressure	Massage
Research	Performance Training
Manual Therapy	Hydrotherapy
Marketing	Myofascial Release
Healing Touch	Craniosacral Therapy
Tellington Touch	Nutrition and Exercise

VET PT SIG UPDATE

Gwynne Oakes and Lin McGonagle traveled to Orlando in June to present the following action items to the Orthopaedic Section Board of Directors:

1. We asked that a public relations letter be sent to veterinary associations and specialty groups to let them know about the SIG, our goals, and ask them to establish liaisons to exchange information, plan educational programs, share resources and promote collaboration on research. We plan to the certification and education plans as well so that we can incorporate their ideas and truly make our programs a cooperative effort. This request was approved. A letter has been drafted and provided to the Public Relations department of the Section.

2. We asked that the section create an International Veterinary Physical Therapy Association. This would involve sending a letter of invitation to all countries that have groups supporting physical therapy for animals. We would start with a simple exchange of newsletters. Within two years we would plan and co-sponsor an international conference in the U.S. The Board supported the formation of this international organization. They requested that we approach WCPT and try to establish a subgroup much like Women's Health. They agreed to exchange newsletters with interested countries. WCPT has been contacted. We are awaiting forms to establish a subgroup. A letter for Canada, United Kingdom, Australia, South Africa, Netherlands, Sweden, Germany, and Finland is being drafted.

3. We asked the Board to investigate and approve a Certification Process for Veterinary Physical Therapy. The Board agreed to investigate this process. They will be involved in periodic review of our progress and feedback from veterinary associations.

4. We asked that a letter relating to the practice of physical therapy be distributed to veterinary associations and organizations as part of practice protection. It was brought to the Board's attention that there are many nonphysical therapists practicing and publishing articles on physical therapy. Mimi Porter, ATC has been one of the most public cases. The Board was notified that the Kentucky State Attorney General has issued a "Cease and Desist" letter to Miss Porter. It was agreed that no specific action regarding Miss Porter was needed at this time. Information about the legal protection of the term "physical therapy" and "physical therapist" can be included in the public relations letter.

We met with Dorothy Santi, PT who is the Treasurer for the Section. She generously provided a training session on SIG procedures and budgeting. A manual will be available soon that outlines what we are supposed to be doing!

The VET PT SIG has a $5000 annual budget that is effective 1 January 1999. Our costs are related primarily to providing programming for Combined Sections. We allocated funds to cover the expense of printing and distributing the Veterinary Physical Therapy Resource Manual and a national directory. These documents will be available as soon as our funding is accessible in January. There will be a discount for Orthopaedic Section members.

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

Limited supply available.

$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

98-2 Home Study Registration Form

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For clarity, enclose a business card.

Mailing Address _____

City _____ State _____ Zip _____

Daytime Telephone No.(_____) _____ APTA# _____

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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.

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Signature _____

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

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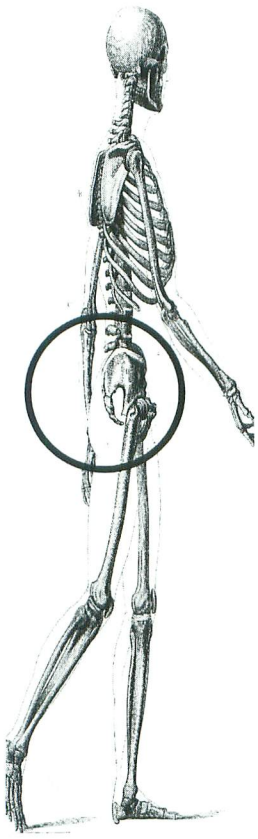

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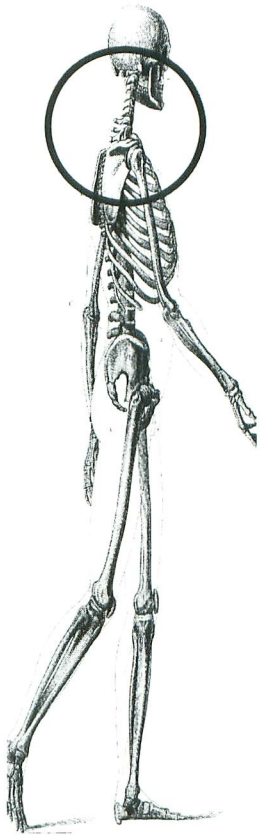

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