PRESIDENT'S MESSAGE

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Tennessee Triumphant! Imaging Victory for the Volunteer-State – And Here's Your Holiday Present: A Guide to Removing the Pain in the ReBUTTal! Moving from Permission Seeking Supplicant to Effective Advocacy and Engagement – Responses to the Age-Old Objections and Challenges from Uniformly Uninformed Stakeholders/ Lobbies/Recalcitrant Rivals. - Imaging SIG President's Message

Cherished Members of the Mighty Imaging SIG!

My o' my, the holiday traditions are near. My wife and I just celebrated Hallowe'en with my paprika-forward, hostilely-spiced Goul-ash, and we just can't wait to engage the rest of the days of cheer and goodwill!

'Tis the season for family, friends, togetherness, thankfulness, and the usual seasonal holiday spats, gripes, and anxiety-provoking holiday stress-planning … Yes, indeed, a time to celebrate, re-explore, and rehash our unresolved issues and conflicts … and who am I to break tradition? (I know… so dark, so quickly, but all with playful ridicule, I assure you!).

You may have to suspend your disbelief, but I love the holidays, so why not **let's** get cozy and talk about our relationship with our stakeholders? It's rainy in Seattle, and I'm feeling warm with cheer already… so who needs a yule log when we can collectively warm ourselves with a hot cup of attitude? What could be more appropriate than an inspiring seasonal airing of grievances? Let me gird myself with prickly mistletoe and untighten a cinch on my red suit and *away* Prancer, Vixen, Dancer, er… I have no idea… *onward* Pixie, Trixie, Gertrude, and Gaston? Whatever… It's been a while since I've read *The Night Before Christmas*.

Anyhow, where *does* this 'age-old' tradition of lament hail from? Let me brandish my turkey carving knives and take a stab at it. I think it's all about communication and the desire to be heard on a raucous stage of competing voices and interests that may or may not have anything to do with the public interest. **We** physical therapists do **not** feel particularly heard.

We feel we aren't being used at the top of our practice nor being leveraged for the service that can provide for the public's interest in the face of escalating physician and nursing shortages in the face of the fourth most significant global health burden: neuromusculoskeletal conditions, injury, pain, and disability. You may have noticed, as have I, that we are seeing more journal, newspaper, and editorial articles from peers, public health officials, and, most importantly, our patients reporting that they cannot find primary care physicians. The wait to establish themselves with a primary care physician is horridly long. To add to the pressures of our severely strained medical workforce, physicians must keep up with a blizzard of new medications, new science and discovery, new interventional techniques, and paradigm-shifting innovation, which must be understood, assimilated, integrated, and applied. So, to the physicians, we cheerfully proclaim. HELLO, folks, physical therapists to the rescue! You need our help, and we can take care of a bunch of the primary care load for many patients who benefit from our many specializations. Our profession has evolved over a hundred years, and we have something to offer.

But hang on; do we bear *any* responsibility for this? Are we communicating our professional complexity and relevance to our peers, the public, and legislators? Or are we good at grousing about it and finding self-sabotaging narratives directed at each other in a Christmas-wreath-shaped firing squad? I argue that we are great at communicating with our patients but not so much with our colleagues.

We can't expect our uniformly uninformed interdisciplinary colleagues to know about physical therapy, nor should we expect them to take a deep dive into the world of physical therapy. This perilous absence of information creates an environment ripe for self-serving rivals to exploit and seize misleading narratives to direct bad public policy for turf control regardless of the patient's interest.

Consequently, I would argue that our *non*-engagement constitutes sub-par care for our patients and legislators' respective constituents, notwithstanding the added reality that some of our well-moneyed stakeholding rivals may also further compromise the judgment of our reelection-seeking lawmakers. However, knowledge is a strength that we can leverage to shape public policy.

GETTING OUR GAME FACE ON

Our *game* ultimately has to improve. Communication has to be pitch-perfect to deflect and disprove false narratives and to highlight the bright light that is primary physical therapy practice. The great news is that our rivals, recalcitrant stakeholders, and even our colleagues (bless their hearts) keep bringing up the same boiler-plate platitudes, chestnuts, bogeymen, yarns, catastrophization, inexplicably inane and unlikely scenarios untethered by reality, hearsay, unverified reports and statements blissfully unburdened by evidence. It never really changes much… shame on us for not matching this crazy-making with a readily delivered elevator pitch.

When promoting ourselves, we ***must*** proudly reflect upon what we offer and emerge from our professional introversion to channel our passionate inner advocates for the public. But to advocate, we need a script, an elevator pitch, something quick, some response ready for the right prompt, challenge, disingenuous narrative, and comment. We have to seize the narrative before someone else does, and we have to be ready.

You've heard or read it before:

1. "You do not *rise* to the occasion.
   You *sink* to your lowest level of preparation."
   – Chris Voss
2. *"Luck* favors the *prepared*."
   – Louis Pasteur
   Okay, not really… Louis said, "Chance favors the prepared mind," but I think you understand.

So, how do we respond to the shrieks of objection, beat back the bogymen, roast the old chestnuts, disentangle the worn-out yarns, and shine the bright light of truth and clarity on false narratives and evidence-free assertions? All the while, not react with surprise like a reindeer caught in headlights.

Easy. The first step is to anticipate the age-old objections and use our prepared scripts, as I've already telegraphed! Make them short and snappy for maximum impact to land on target. The truth is that when you're in a room with physicians, legislators, and lobbyists, you will have limited time. This is the land of soundbites where people have limited attention spans. I mean, no small wonder why TikTok is so popular. If you're lucky, you'll have minutes, but you want to be on point and word-ready… all with sincere engagement. With this preparation, your testimony will be much more compelling when called on as a subject matter expert.

Oh, I can hear your collective groan. Ugh, this sounds like work. But fear not—with season-appropriate joy and goodwill, I come bearing gifts!

As your not-so-secret Santa, ho-ho-here I am to tie a red imaging SIG bow around a gift basket of selected home-spun responses and rebuttals to stuff into your socks and heads. Let me remind you of three resources that we will post on our Imaging SIG page in the New Year that deal with all the hot-button issues we face in PT-directed imaging referral and PT-administered Ultrasound imaging. I am excited to share this supportive evidence, precedent, and institutional support that confirms our primary care suitability to our cause and mission.

THE CHALLENGES: FOR THOSE WHO ARE ABOUT TO ADVOCATE, WE SALUTE YOU!

Whether you are aware of it or not, every day you practice physical therapy, you are in the arena of advocacy. At any rate, these are the challenges/questions/assertions raised by stakeholders and legislators during the three years of my term. Some are legitimate concerns, some flirt with demeaning intent, and some are due to a complete lack of awareness. Some challenges are downright odd. Some challenges come as suggestions designed to slow our progress. So, get ready for the old platitudes, slogans, false equivalences, and bromides, and get suited up for advocacy. The responses are meant to educate and defend, often simultaneously. If you have some crafted responses, by all means, send them to me, but try to make them short and snappy, like I said. It's all hands on deck here on the good ship I-SIG. Here we go:

CHALLENGE #1
Assertion questioning the evaluative nature of physical therapy:

"Physical therapy is an intervention; It's not a diagnostic profession. You are an intervention, not a diagnostician."

Preparatory considerations and analysis for your response: A physician came up with this one. This physician was a friendly referral source to a highly respected vestibular DPT specialist in private practice. His intervention vs. diagnostician challenge stemmed from a vestibular referral. His referral sources often refer patients so they may receive an accurate vestibular diagnosis to guide best-practice interventions.

First off, your response to the statement has to be empathetic. There is no way for a physician to understand our profession and depth of specialization and education adequately. To them, we *are* simply an intervention. However, in correcting the assertion, it is essential to avoid 'shaming' your conversational partner. Try to put yourself in the physician's shoes, who is probably overwhelmed by clinical care, patient load, and administrative demands and doesn't have the bandwidth to look into our profession. Or he could be an egomaniacal bully, which also happens, so let's not be naive. Second, acknowledge the misunderstanding and *'own'* that physical therapists do not communicate the nature of our profession well, and yes, *apologize*! Take the temperature down a few notches, as your rival may not understand how inflammatory their statement was. Take a breath. Calm yourself. Here's our response!

YOU: Dr. Stakeholder, I… *sincerely*… apologize that we left you with that impression, and I think that's on *us* as physical therapists. We don't tend to brag about our profession, and it's *clear* that we haven't adequately communicated our role in multidisciplinary care to you. I think your perception of our profession is *understandable*. As a busy physician managing your practice, you're accustomed to prescribing treatment and therapies, so we fall into the category of *intervention* for you. But we are *so much more*, and it's become abundantly clear to *us* that we need to re-introduce our multi-specialized profession because of this information gap.

I think people are left with the impression that all we do is benevolently help patients and loved ones with total hip replacements down the hospital corridors.

As doctoral-level trained primary care practitioners, we're the first point of contact for many patients for a range of conditions, the most familiar to *you* being neuromusculoskeletal conditions. So, we evaluate, screen, and manage various conditions, including neuromusculoskeletal or acute and chronic orthopedic pain. When we *do* accept referrals from our multidisciplinary colleagues for anything ranging from neuromuscular, vestibular, cardiovascular, and pulmonary, pelvic health issues, we are mandated by our licensures to *evaluate* a patient to form an appropriate plan of care. In *some* States, we call the assessment findings a *physical therapist diagnosis*; in others, it's a *diagnosis* or *diagnostic impression*. At any rate, Dr. Stakeholder, if you don't mind me being *candid* with you, it's in all our *best* interest that our evaluation is *ongoing* to adjust our interventions according to your patient's response to treatment and that we alert you to any changes that may require modifications in our rehab trajectory and frankly, additional referral for other options, therapeutic or otherwise. Yes, we don't want to be alarmists, but we're always looking for confounding, complicating, if not nefarious, findings. Ultimately, it's all about exemplary patient care.

DR. STAKEHOLDER: *What exactly do you mean by 'primary care?*

YOU: So, to be clear, this means that, as primary care providers, we're often a patient's first line of contact.

I realize that you may be unfamiliar with our specializations, to no fault of your own… *heaven knows* how much physicians have on their plate to heroically keep up with medical interventions and research. However, physical therapists

play a crucial role in the differential screening of additional relevant underlying conditions and findings, which may surface during a patient's physical therapy assessment, treatment, and longitudinal follow-up.

Rest assured, our primary care responsibility and training include a duty to refer patients to medical colleagues when the patient's condition is beyond our scope of practice or when the patient is not responding to conservative management.

CHALLENGE #2
A startling question from left field re-litigating direct access primary care physical therapy status:

"You have primary care/direct-access privileges for physical therapy? Since WHEN?" (Genuine expression of surprise)

Preparatory considerations and analysis for your response: This one keeps coming up whenever we advocate for *anything*. It is vexing. Woefully uninformed rivals try to *relitigate* this. It's an annoying distraction that derails honest discourse. It usually devolves into a hysterical concern regarding cancer detection. However, it's best to counter it because it routinely comes up.

YOU: Oh, dreadfully sorry that you weren't briefed on this! We *do* try to remind our colleagues, but I think everyone is dealing with the rapid developments in their *own* specialties, and understandably, ours just becomes part of the background noise… *Heaven knows* how much you physicians have on your plate to heroically keep up with medical interventions and research.

Nebraska was the earliest state to have direct access to PT care in the 1950s. The vast majority of states have direct access language in their practice acts. But once again, our practitioners have an ethical, if not legal, duty to refer to our medical colleagues when the patient's condition is beyond our scope of practice or the patient is not responding to conservative management. This is precisely what we are trained for.

And by the way, the first point of contact primary care physical therapy winds up being a real cost-saving solution to spinal care… just to bring this back to imaging referral, physical therapists know that if a patient gets a spinal MRI first rather than seeing a physical therapist, that patient is six times more likely to have surgery, five times more likely to have an injection, and four times more likely to have an ER visit. Though we want the option to refer for imaging for more suspicious and potentially nefarious conditions, when our patient exhibits 'red flags,' we rely on our physical examination and the patient's response to conservative care.

CHALLENGE #3
Ye olde and moldy cancer bromides and platitudes:

"But what if you miss cancer?" or "What if they have cancer?"

Preparatory considerations and analysis for your response: Be prepared for this one, as we are back to the fearmongering presumptions that we *will miss cancer*. This question often follows the stakeholder's desire to relitigate direct access but can come up spontaneously as the conversation unfolds. We tend to get caught like deer in headlights on this one because it's an odd question with a difficult entry point. The answer *feels* like you have to elaborate, but you don't. You're not here to litigate oncological treatment. Stick to your conviction and your education, and be clear that **cancer, infection, and nefarious conditions are always on our radar and part of our '*differential.*'** You don't even need to say *diagnosis*. The 'cool kids' in medicine use the word '*differential*' alone.

By the way, if the physician is overwhelmingly concerned about expedient detection of '*mets*' (cool-kid-word for metastasis) and *mass* (oops there I go again), all the more reason we should order imaging for the patient.

Also, throw a curveball of your own in there. Our stakeholders don't know that we actually have oncological physical therapy specialists that we can leverage to our advantage. The fact is, peer-reviewed research shows that physical therapy is safe and desirable for people with a diagnosis of cancer. Have you ever used the term 'movement is medicine?"

Go ahead and use it.

YOU: Thanks for bringing that up, Dr. Stakeholder. I'm *glad* you're concerned about it because ***we are, too!*** Mets, masses, infection, and other nefarious systemic conditions are always on our radar and part of our '*differential.*' It's part of our doctoral-level training. As I mentioned, we have an ethical, if not legal, duty to refer to our medical colleagues when the patient's condition is beyond our scope of practice or when the patient is not responding to conservative management.

But here's something to consider, Dr. Stakeholder. Let's say we DO have a patient who doesn't respond to conservative care and, worse, exhibits red flags suggestive of nefarious pathology. Is it not to the patient's advantage and interest to order imaging studies expediently?

DR. STAKEHOLDER: That's easy. Just refer them to their primary care physician!

YOU: Not everyone has a primary care physician, especially in this environment of worsening physician shortages. In rural areas, we may be the only person with training who can refer them to radiology.

I think we would *all* want to be treated by a physical therapist with access to imaging referrals instead of being sent for another trip to the primary care physician, PA, or NP. *We* believe in having all the imaging ready for the physician or surgeon so that they can make quicker and expedient decisions. The combination of a patient having undergone a trial of conservative physical therapy and following up with imaging studies in the case of a non-response to therapy, if not the outright detection of red flags, helps screen and triage patients for a more streamlined delivery of care. The physician, bogged down by a busy practice, surely would rather have patients better suited to their specialized interventions and medications. We are not here to *compete* but to better serve the public with all our colleagues.

DR. STAKEHOLDER: I don't think you have the education to diagnose cancer.

YOU: I assure you, we aren't here to treat *cancer*; we work cooperatively with our physicians and patients. But as I *said*, cancer, infection, osteoporosis, and pathological fracture are *always* part of our differential. By the way, I'm not sure if you're aware, but we also have *oncological* physical therapy specialists. The fact is, peer-reviewed research shows that physical therapy is safe and desirable for people with cancer diagnoses. It turns out that 'movement is good medicine?'

DR. STAKEHOLDER: Yes, but physical therapy is rough on the patient. And I worry about you working on patients who may be at high risk for pathological fractures and cancer.

YOU: Physical therapy is individually tailored to the patient's tolerance. *That's our training*. We're trained to be careful and safe. What keeps *us* up at night are the uninformed, unevaluated, at-risk individuals who may be balance-impaired or continue to use poor body mechanics and musculoskeletal loading on compromised structures. Physical therapists have a vital role in preventing worse issues.

DR. STAKEHOLDER: Are there any lawsuits pending against physical therapists for misdiagnosis?

YOU: Nope, there's nothing in the peer-reviewed literature. Our state boards are always on the lookout for negligent conduct, and this is just not an issue. There aren't even case reports in the body of literature.

CHALLENGE #4
Assertion designed to question physical therapy education:

"You don't have our education (to order imaging)."

Preparatory considerations and analysis for your response: Boom. Just like that by a physician. This is a thinly disguised variant: *"You are not qualified to order imaging."* It's a tricky statement laced with the false presumption that one needs a full medical degree to order imaging and that any other degree is inadequate.

YOU: I'm not contesting that *your field of specialization has* its own specific education, so yes, we don't have ***your*** education. But you don't have *our* education either. We specialize in neuromusculoskeletal management with institutional and peer-reviewed evidence-based recognition of our abilities. Yes, our doctoral-level education includes radiology. This does not mean we are 'radiologists,' but we *can* order imaging. We've been doing it in the DOD since the 1970s, and we've shown in the literature that we order appropriately, judiciously, and to a lesser degree due to our execution of good physical assessment skills. By the way, the DOD recognizes us as NMSEs (neuromusculoskeletal experts).

DR. STAKEHOLDER: Well, maybe in the DOD, but that's different.

YOU: With all due respect, Dr. Stakeholder, it's the same education and the same doctoral degree.

DR. STAKEHOLDER: Well, I don't believe a physical therapy degree is adequate.

YOU: *-adequate?(spoken with a slow up tone)*

DR. STAKEHOLDER: Yes. Physicians are the only qualified providers who should be ordering imaging.

Impasses - Considerations and analysis for your response: At this juncture, Dr. Stakeholder appears to be holding you at an impasse. Try to understand the roadblock by addressing their concerns. It's where your empathy will be challenged. Don't focus on winning the argument but demonstrate your desire to deepen your understanding of the stakeholder's concern. It may very well be a concern for the physician. *However*, it may be that the physician feels threatened by competition and is concealing this. Regarding the competitive practitioner, you can use the response from the previous question, which addressed expedient care for properly triaged patients.

YOU: I see. I really want to understand your concerns. Are you worried about patient and public safety?

DR. STAKEHOLDER: Yes.

YOU: I see. Perhaps I haven't communicated it *clearly* enough. Still, I can assure you that peer-reviewed studies show that we do this well and that we are far less reliant on imaging referrals than other professions, including physicians, by and large. Furthermore, there have been no accounts or lawsuits involving physical therapists and imaging. Do you mind me asking so that I can understand more fully? I'm wondering whether you believe that a full physician's medical degree is required to order imaging.

DR. STAKEHOLDER: yes.

YOU: Thank you for clarifying that. I need to mention that *non*-physician, *non*-doctoral level NPs, and PAs are also ordering imaging. *We* are doctoral-trained professionals ready to step in and serve the public in a spirit of collaboration with all our multidisciplinary colleagues.

Considerations and analysis: Don't be surprised if the conversation devolves or derails toward more questions about our professional education. See Challenge #5.

CHALLENGE #5
Assertion: Dismissive

"Your doctorate is a perfect example of 'degree inflation."

Preparatory considerations and analysis for your response: This is a chronic gripe from stakeholders within and without our profession, and it *does* come up once in a while, and you'll need to thoughtfully counter this dismissive missive.

YOU: I understand that *our doctorate* feels like it might have come out of nowhere for *you* – I'd imagine that with all

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these endlessly evolving medical developments, research, interventions, patients, and administrative load that you have to keep up with, it's *got to* feel like drinking from a fire hose! And the last thing you're thinking about is how our profession has advanced. *But just like all specialized medical sciences* that advance, ***we also*** needed to evolve toward the doctorate to reflect the depth of our discipline and specialization.

CHALLENGE #6
Assertion and questions re. Utilization concerns about physical therapy:

"Physical Therapists will start ordering imaging like kids in a candy shop!"

Preparatory considerations and analysis for your response: Seriously, some physicians, flanked by several more, said this! This is pretty demeaning. Can you imagine if we felt we had the liberty to say this to them? It's pretty inflammatory, actually. But you know what? We know something about inflammation. Lean into Tim Flynn's statement from the slide deck.

CHALLENGE #7
Assertion re. Ionizing radiation:

*"You're going to order **so many X-rays,** you're gonna turn our patients into **glow sticks!**"*

Preparatory considerations and analysis for your response: Okay, I totally made that one up… I just couldn't resist.

However, this leads to an actual position statement from the American College of Radiology (ACR) when they were solicited for a truly awful and uninformed opinion during Iowa's successful legislative play for imaging referral privileges. The ACR offered a poorly cited opinion, falsely conflating the overblown concerns of a 2015 JAMA article submission involving non-physician imaging referrals that did *not* include physical therapists. Iowa, under the leadership of APTA-Iowa president Dr. Kory Zimney, still pulled it off, drawing from a steadfast evidence-based rebuttal.

This leads to the next assertion and, as I foreshadowed, bold false equivalency.

CHALLENGE #8
Assertion: Physical Therapists will order more radiography, exposing patients to more ionizing radiation based on the 2015 JAMA study on non-physician radiography referral!

Preparatory considerations and analysis for your response: This blatant false equivalency is an example of a colossally deceptive distortion and conflation that is, frankly, beneath the dignity of the ACR. This is beyond 'cherry-picking' and beyond the pale. This is particularly upsetting as physical therapists revere, cherish, and follow the ACR guidelines. As University of Illinois' professor Dr. Aaron Keil, DPT, showed during our membership meeting in Spring 2024, the JAMA 2015 study only included PAs and NPs as the non-physician group and compared them to physician referral. However, to be fair to our PA and NP colleagues, the article only *suggests* a concern for increased ionizing radiation in the discussion. In actuality, the results only show a modest, or, as Dr. Keil shows, a slight increase in radiography referrals compared to PCPs (only 0.2-0.3% more!!). Moreover, the authors demonstrated that advanced imaging orders were *not* significantly different from PCPs (0.1% more!). Here's the kicker that the ACR *doesn't* mention. The study concludes that non-physician involvement in radiological referral may *alleviate* the effects of primary care physician (PCP) shortages.

So, talk about disingenuous! We have to call it out. BUT here's the interesting twist. There are two avenues of response:

1. Dr. Kory Zimney's response to the ACR opinion. Kory reinforces that the JAMA study does not include physical therapists. He used the opportunity to say that physical therapists are doctorly trained compared to NPs and PAs who are masters level trained. Simple and effective. Team Iowa was max-prepared and had cultivated excellent relationships with the legislators who welcomed his messaging.

2. Lean into the facts of the article.

YOU (channeling your inner Kory Z): We totally agree with the concerns of the ACR in terms of radiation exposure, but this study only deals with master's level education professionals of NP and PA compared to PCPs. The study did *not* include physical therapy. In comparison to the professions that were studied, *we are a doctoral-level profession*, and the evidence is clear that we are far less likely to jump at an imaging study because of our strong physical assessment skills. Non-musculoskeletal disciplines are far more likely to use imaging as a first assessment referral. So, yeah, it doesn't apply to us.

YOU (the I won't back down-evidence-based physical therapist): Ah yes, and we physical therapists *absolutely* share the concerns of over-exposure to ionizing radiation. The evidence shows that physical therapists are *far* less likely to rely on imaging studies due to the strength of our physical examination. But I'd like to talk about that study for a minute. *That JAMA 2015* study only dealt with master's level education professionals of NP and PA compared to Primary Care Physicians. The study did *not* include physical therapists. In comparison to the professions that were studied, *we are a doctoral-level profession*. As I said before, the evidence is clear that we are far less likely to jump at an imaging study because of our solid physical assessment skills. While non-musculoskeletal disciplines are far more likely to use imaging as a first assessment referral, the evidence shows we are very judicious in imaging referral. So, while I *appreciate* and share the concern about over-exposure to ionizing radiation, it simply *doesn't* apply to us.

But I think we *have* to be fair to our NP and PA colleagues. The JAMA article actually *shows a slight increase in radiography referrals compared to PCPs (only 0.2-0.3% more!!). AND most notably, the article demonstrated that advanced imaging wasn't significantly different from PCPs (0.1% more!).* Here's the kicker that the ACR *doesn't* mention. In fact, the study concludes that *non-physician* involvement in radiological referral may *alleviate* the effects of primary care physician (PCP) shortages.

1. Hughes DR, Jiang M, Duszak R, Jr. A comparison of diagnostic imaging ordering patterns between advanced practice

clinicians and primary care physicians following office-based evaluation and management visits. *JAMA Intern Med*. Jan 2015;175(1):101-7. doi:10.1001/jamainternmed.2014.6349

CHALLENGE #9
Question about 'wet reads'

"you can't read a wet x-ray," or *"you can't do a wet read."*

Preparatory considerations and analysis for your response: 'Wet read' is cool-speak for a preliminary, quick initial, pre-radiologist read of an imaging study, typically done in the ED. The term is a historical reference to the time when X-ray films were still being processed, and the plain films were still physically wet. This is a weak argument, but you need to deflect it quickly and matter-of-factly.

YOU: Dr. Stakeholder, I understand that you can't believe how much our profession has evolved. With all that you have to keep up with, there's no way you can know about ours. You may have to suspend your disbelief, but we aren't too shabby at it to at least help us preliminarily manage the patient.

But rest assured, ultimately, we would never hang our hat on our findings or preliminary interpretations. For example, I'd tell the patient, "Hey, Mr/Mrs. Patient, I'm concerned/suspicious about (given condition), but we need the radiologist's eyes to diagnose the images. In the meantime, until we get word from the radiologist, I don't want you to put any weight through the limb, and I want to keep it braced…"

Let's face it, in rural areas, I might be the only person available to refer that given patient for imaging.

CHALLENGE #10
Statement made by physician-turned-legislator during state House of Representatives negotiations:

"I can't see physical therapists ordering MRI. It's a matter of patient safety. I will compromise by allowing you to refer for radiography plain films."

Preparatory considerations and analysis for your response: This was particularly annoying. This physician was the only committee member blocking a legislative win. But he invoked the fear for patient safety. We weren't fast on our feet with a response and capitulated by settling for plain films. The good news is that when this physician exited from politics, team Arizona executed perfectly and got full privileges passed. But here's the response to the statement we might try if it happens again.

YOU: I see. It seems that you don't want us to order MRIs due to patient safety concerns. It is abundantly clear that the patient is your highest priority. Am I getting that right?

DR. LEGISLATOR: Precisely.

YOU: I have to share with you that patient safety is *also our highest priority*. It just seems a little confusing that the compromise you're proposing is to allow us to order imaging that uses ionizing radiation, but you *don't* want us to use MRI, which uses none whatsoever.

DR. LEGISLATOR: Um …you can't interpret an MRI. That would be dangerous for the patient. You'll misdiagnose the patients.

YOU: Of course, I'm not going to interpret the MRI. That's the radiologist's job. That's why I want to send the patient to the radiologist and await the report like everyone else. I will, of course, want to see the images to understand the underlying pathology better. So, there's no chance that I will misdiagnose. It's a matter of course to leave the reading of the MRI to the radiologist.

Post-analysis: You'll probably win this one if you testify before a full committee, as it constitutes more of a debate forum. In this format, the aim is to win the debate. The issue in the final analysis that remains is that the physician may still be concealing the real reason why they object to physical therapist-directed referral.

CHALLENGE #11
Hearsay and the personal, unverified anecdote to vilify physical therapy:

"We had a patient that was blah, blah, blah, and the physical therapist did yada yada…"

Preparatory considerations and analysis for your response: Your response should be tweaked or adjusted depending on the venue, whether you're at a stakeholder meeting or an actual legislative debate.

To defend and defang an unverifiable 'event' or 'accusation' that constitutes hearsay, your job is to invoke evidence. You will have to get ready to challenge that person with hearsay of your own. You will have to ask what evidence they have to support their claim. You *must* state that their statement is unsubstantiated and constitutes hearsay. You may even ask, with sincerity, if they reported the incident. This is a game of tit-for-tat… so be ready with your tat!

YOU: Well, respectfully, Dr. Stakeholder, you're bringing up an isolated incident we can't verify or study to know exactly what happened. I'd be curious to know if the danger was so imminent that our board should have been notified so that we *could* study the incident thoroughly. We *are* dedicated to protecting our public, so I implore you to communicate with our board to verify the event and, if necessary, discipline our licensee.

But to be fair, Dr. Stakeholder, in counterpoint, I can tell you a lot of times that the physician made the wrong call for the patient, but really, I think we're getting into a 'tit for tat.' These anecdotes do *not* constitute evidence that we can *hang our hat on*. I don't think our legislators benefit from hearsay. However, if you have any peer-reviewed evidence or research to back your claims, I'd love to see it.

Do you have any peer-reviewed evidence to help guide the discussion?

CHALLENGE #12
Questions re. Conflicting diagnostic findings related to physical examination and ultrasound imaging:

"What if your diagnosis is different than mine? What happens if you come up with a different diagnosis than mine?"

Preparatory considerations and analysis for your response: This curious, eyebrow-raising question came from a physician. Would this same physician have posed this question to another physician? I sometimes wonder if this question arose from diagnostic insecurity or genuine concern for the patient. I also wonder if the notion that a physical therapist's diagnostic impressions are perceived as a challenge instead of a *contribution.* From my perspective as a physical therapist, I am here to serve the patient and the patient's team of providers. So, this question is anathema to my mission to provide the best care I can and to report findings that may shed more light on a patient's condition and response to treatment. I think, in part, that this 'odd' question comes from an 'old-guard' interdisciplinary dynamic.

I repeat the question: "Would this physician ask the same question of a physician colleague who had some new or contributing findings or even a different or added diagnostic determination?" Nope, they would chat and agree or disagree and order some more tests or change the course of treatment without fanfare or friction. So why is it different if a physical therapist, during the initial physical evaluation, detects an additional problem or diagnosis among a constellation of musculoskeletal problems that may require some modification in treatment? Conversely, why is it different if we find something that can explain a given patient's potential non-response to treatment or a slower-than-anticipated recovery? Is it not our duty to provide a vigilant evaluation of the patient's response to treatment? Who better to check for contributing findings than the physical therapist? After all, we have the distinct advantage of seeing the patient in repetitive sessions. So, here's your answer. *Remember, your goal is to acknowledge the stakeholders' concerns.*

YOU: I think I understand. It seems that you're worried that our diagnostic findings might be a source of *confusion* for the patient's care. I can assure you that it's *not* our goal to challenge your diagnosis. It's doubtful that we will contradict your findings or diagnosis.

However, our licensure mandates that we perform a physical examination and report our findings to inform the multidisciplinary care team. Chances are that, during our assessment, we may encounter additional findings that will impact the patient's recovery and help us navigate a safe rehabilitative trajectory.

Also, it's our duty to evaluate the patient's response to treatment vigilantly. When possible, we need to report findings that explain a given patient's non-response to treatment or a slower-than-anticipated recovery. We are forever concerned about potential red flags, so we have to be ever-ready. We are lucky that we have the distinct advantage of seeing the patient in repetitive sessions.

Much like when you discuss the *differential* with your physician peers, we'll report any evolving concerns we uncover that may affect the patient's treatment. We're here to help, not hinder.

CHALLENGE #13
Question: *"Why do you want/need to refer patients for imaging studies?"*

Preparatory considerations and analysis for your response: The answer seems obvious enough until you have to come up with a quick, snappy answer without relying on *"um, like, kind of, you know,"* etc. Your job as an advocate is to quickly relate why it's essential to your patients. Don't forget that you have to explain yourself to people who may not know what you do. Don't expect the physicians and nurses to understand the depth of your profession and education either. To most people, including your interdisciplinary colleagues, you are a kindly taskmaster who walks their dear parent down the hospital corridor and persuades her to get out of bed after a total hip replacement.

YOU: Thanks for asking. As doctoral-level trained primary care practitioners, we're the first point of contact for many patients with a range of conditions, the most familiar to *you* being musculoskeletal and orthopedic conditions. There are times when, during our physical evaluation or the course of the patient's rehabilitation, we may detect findings or red flags that require quick and timely imaging studies. Instead of referring the patient to the physician, NP, or PA, we can and want to order imaging studies directly from the radiologist instead. This is less expensive and more practical care for the patient. Patients don't like to wait for an additional visit to a provider only to be told that they need imaging, resulting in more delays.

To top that off, not everyone has a PCP, especially in this environment of worsening physician shortages. In rural areas, we may be the only person with training to refer them to radiology.

I think we would *all* want to be treated by a physical therapist who has access to imaging referrals instead of being sent for yet another trip to the primary care physician, PA, or NP.

Regarding surgical or interventional consultations, *we* believe in having all the imaging ready for the physician or surgeon so that they can make quicker and more expedient decisions.

Using us in *this* way *streamlines* care delivery for our orthopedists and physicians. *For example*, suppose a patient comes to us for a trial of conservative physical therapy and winds up unresponsive to therapy, or we detect some red flags. In that case, we can quickly cue up some appropriate imaging studies so that by the time the patient goes to the orthopedist, the imaging is ready for quick action or decisions by the physician. In this way, we play a role in screening and triage for our physicians who are bogged down by their busy practice. I'm sure that our physicians would surely rather see patients who are better candidates for their specialized medications, surgical or non-surgical interventions.

Again, we are not here to compete but to better serve the public with all our colleagues.

Finally, I'd like to make the final point. I can't count the times we call our primary care physician, NP, and PA to order specific imaging for the patient. Very often, *they* ask us *which* imaging studies we need and recommend. Ultimately, this is such a clunky process and a waste of time for our patients who want quick answers. We can do better for our public, particularly in rural and underserved rural and urban areas.

CHALLENGE #14
Questions re. Payers:

"Will insurance companies pay for it?"

Preparatory considerations and analysis for your response: This seems like a good question, but there's a curve ball here. First off, it's a side issue and a distraction. The issue that ***we want*** to address is that physical therapists are capable practitioners and *should* be referring for imaging, and *not* whether the payers reimburse it. However, you *must* address it, as it has emerged as a repeated question by all stakeholders, including worried physical therapists. I am *not* one of them. There are plenty of diagnostic testing and interventions that don't get reimbursed, but that does not stop practitioners and providers from using them. Don't get distracted by thinking you need approval from payers and insurance companies. We must avoid our chronic permission-seeking behaviors endemic to our physical therapy culture.

However, we must be honest and disclose that the ONLY payer issue is with the Centers for Medicare Services (CMS). Much to my irritation, Medicare will not reimburse radiology centers for imaging study referrals from physical therapists. This is because of an exclusion. The CMS list only includes chiropractors, NPs, PAs, clinical psychologists, and physicians. It is my goal to get on that list. I mean, come *on*, man… NPs, PAs, and clinical psychologists but not US? This needs to change, and we will not stop until it happens.

Also, you should absolutely mention that in underserved rural areas in the USA, a great majority of patients rely on Medicare/ Medicaid, and that's for both adults and pediatric patients, notwithstanding the explosive growth of our aging populations who will be on Medicare. We absolutely need to be on that list.

YOU: I'm glad you brought that up. It's *always* on our radar, and the literature confirms that it's a non-issue. Studies show that insurance companies *consistently* reimburse for physical therapist-directed imaging regardless of the pre-authorization requirements for advanced imaging referral.

But let's get even more granular with this while we're on the subject.

I realize that one of the concerns is that the patient will get stuck with the bill, but imaging services are a pre-authorized process. When you get authorization, you get confirmation that the payor will pay. So, no authorization, no imaging. When imaging centers follow typical pre-authorization processes, we are unaware of a single instance in which a patient has been solely responsible for the costs of imaging ordered by a PT.

Also, when it comes to more expensive advanced imaging like MRI, payors will NOT typically authorize it without *prior* radiography (X-ray) imaging, which is far cheaper.

But, for the sake of full disclosure, the ONLY payer issue we face is with the Centers for Medicare Services (CMS). Much to our aggravation, Medicare won't reimburse radiology centers for imaging study referrals from physical therapists. This isn't because we're prohibited from ordering imaging. It's due to an *exclusion*. The CMS list only includes chiropractors, NPs, PAs, clinical psychologists, and physicians. It's our goal to get on that list.

No offense to our dear colleagues… but NPs, PAs, and clinical psychologists but not US? This needs to change, and we will not stop until it does. Did you know that in underserved rural areas in the USA, a great majority of patients rely on Medicare/Medicaid, and that's for both adults and pediatric patients? What are all our busy physicians going to do with the explosion of aging patients who will be on Medicare? We can help eliminate unnecessary additional visits by streamlining the referral process.

We need to be on that list.

CHALLENGE #15
When adversaries witness their capitulation and defeat/weakness in their arguments, the rival attempts to ask for more time to "study the matter more thoroughly due to 'concern' for the public" – invocation of a 'pilot-study':

"We certainly respect our physical therapists. What would we do without them? But, we need to proceed cautiously to protect the public. Maybe what we could agree to is a pilot study so we can better understand the outcomes and prevent any negative or disastrous effects."

Preparatory considerations and analysis for your response: When your rivals do this, they try to slow-walk our profession's progress. Your task is to rebuke them. Assure everyone that if the PT steps out of line, disciplinary actions will take place. Legislators love the idea of punitive and disciplinary responsibility.

YOU: With all due respect, Dr. Stakeholder/Representative/ Senator/ Legislator, there is no need for yet another pilot study. There is enough evidence, institutional support, and precedent supporting physical therapist imaging referral. We don't need to be slow-walked when the studies are clear on this.

Physical Therapists have been ordering imaging since the 1970s in the military services and continue to do so. An expanding number of states include imaging privileges for Physical Therapists, including Colorado, Iowa, Arizona, Nevada, Montana, Rhode Island, the District of Columbia (D.C.), North Dakota, New Jersey, Maryland, Wisconsin, West Virginia, Louisiana, Tennessee, Alaska, and Utah. In contrast, most states remain silent on the matter with no explicit prohibition to imaging referral.

But let's say a physical therapist has been found to violate a given physical therapy practice act; we have our State disciplinary boards, and appropriate actions will be taken.

CHALLENGE #16
CMS doesn't allow PTs to order imaging studies

Preparatory considerations and analysis for your response: This is one I encountered when ordering an MRI for a patient with severe Hemophilia type A who had an infraspinatus avulsion injury that I detected with MSKUS (I'm an RMSK). I referred him to a trusted orthopedic surgeon and wanted expedient imaging ordered, knowing that the surgeon would want an MRI. This patient was NOT on Medicare/Medicaid and had excellent insurance. I quickly got pre-authorization for the patient, and he got his appointment to the radiology department. Here's what happened next.

Despite the pre-authorization, the rad-tech said he couldn't do the study because he never performed one for a DPT before. He turned it over to his compliance team, and they dug up CMS language, which they misinterpreted as prohibiting radiologists from accepting physical therapist referrals. I explained that non-CMS patients had no prohibition, so this patient was exempt from this language. Furthermore, the CMS was not a prohibition but, technically, a *payor issue.* The language states that a radiology provider will not get paid by CMS if a referral comes from a physical therapist. Vexingly, chiropractors, clinical psychologists, non-doctoral PAs, and NPs are referring providers for which radiologists can get reimbursed.

The 'compliance team' interpretation constituted a constellation of hesitation, fear, apparent confusion, and, quite frankly, maybe a little intellectual laziness.

Being on vacation when I had to deal with this, I capitulated as the patient was already in the radiology clinic. So, I called one of our hematology/oncology physicians to co-sign the order to put it through (for me, it was a humiliating exercise, to be truthful). Our hem/oncs rely on us physical therapists for the musculoskeletal differential and genuinely appreciate the role of the physical therapist in the multidisciplinary management of the complex musculoskeletal issues endemic to the bleeding disorders community in the USA, if not the world.

The next step I could have taken was to have a separate meeting with the radiology center's administrative staff to develop a collaborative relationship and explain our role in imaging referral. I will follow up at some point when I'm not doing everything else (sigh).

YOUR ACTION: Make the appointment and schmooze with radiology clinic administrators and radiologists. They are our allies even if they don't realize it! Make them your friends, educate them, and develop your relationship! Remember:

"Go at it boldly, and you'll find unexpected forces closing around you and coming to your aid."

- Johann Wolfgang von Goethe (1749-1832)
German Intellectual,
Author, Playwright,
DPT, OCS, and RMSK,

Okay, he wasn't a physical therapist or an RMSK…and he let his OCS lapse.

CHALLENGE #17
Want to talk about cost savings? You better know your audience before you start!

Quick Preparatory considerations and analysis before you leap into your strategy: You *really* have to *know* **who** you are talking to. You may be a physical therapist who bought into 'value-based physical therapy' and thinks everyone is *into* cost savings. Still, you may need to expand your perspective to include the conflicting agendas within and without our profession. Don't lift that glass of cool-aid to your lips just yet. Your conversations will be different whether you talk to payors and insurance companies instead of orthopedists, hospital institutions, or radiologists. Each group will require nuance and empathy. For instance, let's overly simplify the groups:

Payors and insurance companies: it's all about the money. This is about cost containment, so whether you are talking about direct access or imaging referral, direct your conversation to the ways you can reduce an extra provider visit and assure them that we have the education and ability to do it.

Radiologists: I'm not talking about the ACR here. I'm talking about a potential alliance with radiology groups or chains, which we need to convince that we represent a significant referral source to their businesses while assuring them that we have the education, precedent, evidence, and ability to do it.

ACR (American College of Radiology): This is all about defending our education and providing a more holistic explanation that we have institutional support, context, precedent, and evidence to justify our desire for better public health policy.

Orthopedists and Hospitals: You shouldn't be shocked that these institutions don't give a rat's soggy bottom about savings. They are primarily in the business of making money and improving their bottom line. They DON'T care about 'value-based' physical therapy. They don't know about it and don't want to hear it. So, they don't want to know how imaging referral or direct access can lower the cost of care. They are in the business of increasing visits.

Instead, lean into the fact that you can streamline and triage care for the hospital, helping to direct the patient to the appropriate interventional or surgical physician while assuring them that we have the education, precedent, evidence, and ability to do it.

SPECIAL ULTRASOUND SECTION

CHALLENGE #18
Questions regarding Ultrasound Imaging:

Preparatory considerations and analysis for your response: When you are called to answer this question or anything that pertains to US imaging, it would be enormously beneficial to have a physical therapist subject matter expert respond. What's more, for your preparation, all the information you need is from a heavily cited resource we've created - **Physical Therapist-Administered Ultrasound Imaging: A Review of History, Current Realities, Use, and Institutional Support.** The resource gives you the background, context, use, institutional support, evidence, precedent, and our extensive involvement in ultrasound imaging research. Here's a couple of excerpts:

"Physical Therapists currently utilize ultrasound imaging for evaluative and rehabilitative purposes in the United States and globally. In the USA, physical therapists use sonography for musculoskeletal (MSKUS), neural, spinal, pelvic health (men and women), and cardiovascular/cardiopulmonary applications."

"Physical therapists have adopted ultrasound as a crucial point-of-care (POC) evaluative tool, enhancing and extending their physical examination and differential screening processes. When combined with the physical therapy assessment, the objective data from ultrasound imaging informs and enhances safe, conservative treatment and patient activity management."

DR. STAKEHOLDER: *"Why do you want/need to perform ultrasound imaging?"*

YOU: Thanks for your question, Dr. Stakeholder/legislator. By the way, I'm Bruno Steiner, and I have a doctorate in physical therapy and the gold-standard APCA physician credential of the RMSK for musculoskeletal ultrasound imaging.

Physical therapists are no strangers to ultrasound imaging. As a matter of fact, physical therapists have been pioneering musculoskeletal ultrasound imaging since the 1980s. Depending on our specialties, the way we use it varies. But what remains constant is that we absolutely love the high-definition safe profile of this tool, and we use it as an extension of our clinical and physical exam. So, we use it to corroborate and complement our clinical exam.

In the USA, physical therapists use sonography for musculoskeletal (MSKUS), neural, spinal, pelvic health (men and women), and cardiovascular/cardiopulmonary applications.

In my practice with bleeding disorders, I use ultrasound imaging for joint and muscle bleeds, joint health, and all kinds of orthopedic issues like tendinopathy or tendon and ligament tears. We've even picked up stress fractures, infections, and gout as well. The value of knowing and visualizing the extent of injury and joint destruction allows me to adjust or individualize my treatments to suit the patient better. It provides valuable information for the hematology/oncology physicians and orthopedists we collaborate with and refer to.

I have to tell you, we physical therapists are firmly grounded in anatomy as well as manual skills, so the use of ultrasound imaging is incredibly well-suited for us to extend our physical assessment.

Dr. STAKEHOLDER: How many physical therapists are using ultrasound imaging?

YOU: There are many, but we don't know the exact number. Many of us are continuing our education in ultrasound imaging and getting certified by the gold-standard parent certification body, Inteleos, and its APCA and POCUS academy registries.

Dr. STAKEHOLDER: Is it taught in schools?

YOU: Yes. In the vast majority of doctoral physical therapy programs. *(You don't have to be specific, but it's around 70%, and at varying extents, from didactic to workshop).*

Dr. STAKEHOLDER: How long have you been using ultrasound imaging?

YOU: I've personally used ultrasound imaging for 10 years. I've been using therapeutic ultrasound for 35 years.

Dr. STAKEHOLDER: Do any organizations recognize the physical therapist's use of ultrasound imaging?

YOU: Of course, Dr. Stakeholder. First, our professional corporation, the American Physical Therapy Association, explicitly recognizes ultrasound imaging as part of the physical therapy professional scope of practice. Notably, the American Institute of Ultrasound in Medicine recognizes Physical Therapists as licensed medical providers of MSKUS and ultrasound imaging. Also of tremendous relevance and importance, the gold-standard credentialing body and parent corporation, Inteleos, and their APCA and POCUS registries recognize physical therapist eligibility for their certifications.

To be more specific, physical therapists have been recognized for the incredible privilege of sitting for the RMSK physician credential for MSKUS imaging. This is governed by Inteleos' Alliance for Physician Certification and Advancement. The POCUS academy, in contrast, invites physical therapists to certify for cardiac, vascular, pulmonary, pelvic, abdominal, and, of course, MSK applications.

We are also recognized by the National Bleeding Disorders Foundation's (NBDF) Medical and Scientific Advisory Council (MASAC) as providers of musculoskeletal ultrasound imaging for both image acquisition and interpretation. The World Federation of Hemophilia is also in line with the NBDF. There are more if you need a list.

Dr. STAKEHOLDER: As a physician who uses ultrasound imaging, I'm wondering what happens if *your* findings are *different* from mine. What if your *Diagnosis* is different from mine?

YOU: (please refer to CHALLENGE #11) I think I understand. It seems that you're worried that our diagnostic findings might be a source of *confusion* for the patient's care. I can assure you that it's *not* our goal to challenge your diagnosis. It's doubtful that we will contradict your findings or diagnosis.

However, our licensure mandates that we perform a physical examination and report our findings to inform the multidisciplinary care team. Chances are that, during our assessment, we may encounter additional findings that will impact the patient's recovery and help us navigate a safe rehabilitative trajectory.

Also, it's our duty to vigilantly evaluate the patient's response to treatment. We need to report findings, when possible, that explain a given patient's non-response to treatment or a slower-than-anticipated recovery. We are forever concerned about potential red flags, so we have to be ever-ready. We are lucky that we have the distinct advantage of seeing the patient in repetitive sessions.

But let's entertain your scenario in which I find something else on musculoskeletal ultrasound imaging that complicates the diagnosis.

We can all agree that a patient's condition is in flux, and things can change. For instance, a patient may have attempted to inappropriately load a limb, joint, or musculotendinous structure, which may cause *additional* damage to further complicate the differential. Wouldn't you want us to report potentially important findings as the condition evolves? These changes could happen anytime during rehabilitation.

Much like when you discuss the *differential* with your physician peers, we'll report any evolving concerns we uncover that may affect the patient's treatment. We're here to help, not hinder.

But I have to tell you that we physical therapists enjoy seeing and following up with the patient for numerous visits, so we may very well get a chance to follow up with the patient sonographically to verify the tissue's response to treatment or to verify additional findings. For instance, in my line of work, I have to be vigilant for additional tissue bleeding, myositis ossificans formation, hemarthrosis, hemarthropathy, and inflammatory changes (CHOOSE YOUR EXAMPLES TO MATCH YOUR DISCIPLINE)

DR. STAKEHOLDER: What does your practice act say?

YOU: Our practice acts include sound for treatment and evaluation. There are no explicit prohibitions.

QUICK SUMMARY

Moving from Supplicant to Effective Advocate — Your Counterpunches: Lean in With Conviction, Empathy, Validation, Sincerity… and Respect!

We are a deferential, respectful, and respectable profession. We enjoy a general appreciation from society and the public. Our default position is 'go along to get along,' particularly with our physician and nursing colleagues. That's actually a good thing. But it's also a dual-edged sword that doesn't serve us when we have to confront uncomfortable circumstances and discussions and advocate for ourselves. We tend to lean into our default persona of obedient, permission-seeking supplicant. However, we are great at learning, and that is an inherent strength that we continue to leverage.

Legendary master of hostage negotiator and consultant Chris Voss reminds us that cultivating respect for the other side is paramount to successful outcomes. You will still need to represent and call for the evidence and call out the hearsay, but never lose the center of empathy for your debate partner, even if they 'irk' you with bullying behavior. Try to find out the background and motivations of the 'other side.' Negotiation is not a knife fight. It's about creating bridges for understanding and truly empathizing. We must validate our conversational partners' concerns and echo the interlocutors' concerns. Yes, we may have to dig deep to deal with a perceived 'bully,' the toughest negotiating partner of all. We have to keep things calm, controlled, and empathetic to keep everyone's fight or flight chilly-chill cool (like Santa Claus? Fonzie, anyone?). If we just both turn into hyperreactive combatants, we essentially disengage our mutual empathy and unleash our respective amygdalas on each other. Nothing gets done (and yes, I have to remind myself of that). We need to down-regulate our collective amygdalas.

So, in the final analysis, I guess I'm trying to resist the temptation to air my grievances. Let's channel our concerns positively and leverage negotiation, advocacy, political, and healthcare discourse for the higher purpose of ENGAGEMENT… not battle.

Let's close with the wise counsel of master negotiator Chris Voss:

> *"Here's something that doesn't get talked about enough: respect is the bedrock and foundation of a good debate. Now, don't confuse that with the kind of debate you see on TV—where it's more about entertainment and who can shout the loudest.*
>
> *I'm talking about real debate.*
>
> *One where both sides are heard, ideas are exchanged, and—get this—nobody walks away feeling steamrolled. Respect sets the tone. It keeps things grounded. If you can show your counterpart that you're genuinely listening, even when you don't agree, it shifts the whole dynamic. Suddenly, it's not about who's right or wrong. It's about understanding where the other side is coming from. And yeah, that might not make for the most dramatic back-and-forth. But it sure makes for the most productive one.*
>
> *In negotiations—or any kind of high-stakes conversation—it is **THAT respect** that opens doors. It gives you the space to explore the deeper issues and uncover those Black Swans, the hidden truths that can change the whole game.*
> *So, next time you're stepping into a debate, whether it's over a deal, a decision, or something personal, check the respect levels first. That's what builds the foundation for everything else."*
>
> —Chris Voss

Tennessee Triumphant! Victory in the Volunteer State! Music to Our Ears!

Something is wafting in the air in Tennessee, and it isn't just the sweet strains of guitar and soulful melody out of Nashville. No, indeed, the music to my ears is the sound of victory for the public's interest in Tennessee. Under the leadership of the APTA-Tennessee Legislative Chair, Gretchen Jackson, DPT, flanked by APTA-TN Chapter President Sarah Suddarth and a delegation of brilliant physical therapists: Mike Voight, PT, DHSc, OCS, FAPTA, Jody Swearingen, DPT, MPT, SCS, Christopher Wolfe, DPT, MPT, Ashley Campbell, DPT, SCS, Jonathan Brown, DPT, OCS, and Richard Clark, PT, DSc, SCS.

Team Tennessee was pitch-perfect in a State Board inquiry. It ultimately elicited a confirming ruling for imaging referral by physical therapists! Let's be clear: not only does this further confirm our primary care role, but simply put, it is good public health policy.

Let us encourage other States to join the harmonious chorus of states officially acknowledging physical therapists as providers of imaging referral. But please, don't go it alone, as it is absolutely crucial to be well-*versed* by consulting your friendly neighborhood Imaging SIG. It will be terribly important to strike the right *chord* with your board or legislators. Don't go unprepared when confronted with a dissonant question that sounds like fingernails on a blackboard (does anyone even know what a blackboard is anymore?).

Tennessee, we rise from our own Opry seats and accord you a standing ovation. Bravo!

Irons in the Fire

As usual, I continue to be engaged, active, and optimistic in even more states, but we will keep our cards concealed, as per our state chapters' wishes (though I can't wait to tell you!). We have been relentless but not reckless. There are so many amazing things going on, and I can't wait to tell you all.

In closing

You know my refrain, but if this is your first read of my newsletters, I will close with my familiar refrain of optimism for our profession, and I want to restate that it is OUR profession. Do not give away your agency to another lobby, stakeholder, rival, or opponent. We must reassess our toxic relationships or codependences and create new alliances. An emerging friendship will be found in radiologists at the independent level. We will also begin to talk with the American College of Radiology. It is time to find new friends if our old adversaries continue to obstruct us and, frankly, see no value in us. I know our value. Our patients know our value.

Keep representing!!

I wish you all a wonderful holiday with the family you inherited, the family you chose, your dear friends, and your loved ones. And as my dearly departed mother reminded me, please continue to count your blessings.

Much love and a fabulous New Year 2025.

Bruno

Bruno Steiner, PT, DPT, LMT, RMSK,
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