Vol. 8, No. 3 Summer 1996

Orthopaedic Physical Therapy Practice

AN OFFICIAL PUBLICATION OF THE ORTHOPAEDIC SECTION
AMERICAN PHYSICAL THERAPY ASSOCIATION

THE ORTHOPAEDIC SECTION, APTA, INC.

presents

"CURRENT CONCEPTS: A REVIEW OF ADVANCED ORTHOPAEDIC CLINICAL PRACTICE"

Lower Extremity: November 2-6, 1996

Sheraton Plaza at the Florida Mall
1500 Sand Lake Road, Orlando, Florida, 407-859-1500
Room rates: $89 single/double

Knee: Lori Thein, MS, PT, ATC, SCS
Saturday, November 2
8:30 am-11:30 am; 12:30 pm-3:30 pm

Foot & Ankle: Susan Appling, MS, PT, OCS
Sunday, November 3
8:30 am-11:30 am; 12:30 pm-3:30 pm

Foot & Ankle (cont.):
Monday, November 4
8:30 am-11:30 am

Afternoon Break
Monday, November 4
11:30 am - ?

Low Back/SIJ/Hip: Paul Beattie, PhD, PT, OCS
Tuesday, November 5
8:30 am-11:30 am; 12:30 pm-3:30 pm

Low Back/SIJ/Hip (cont.):
Wednesday, November 6
8:30 am-11:30 am; 12:30 pm-3:30 pm

Level: Advanced (3); Subject Code: (12)

Educational Credit: 24.75 contact hours

Course Fees:

Before October 1, 1996:
Orthopaedic Section Members: $550
APTA Members: $600
Non-APTA Members: $650

°After the early-bird deadline date, add $50 to registration fee.
°Course may be taken in full, or in part. Call the Section office for pricing on portions of the course!

The purpose:

"Current Concepts: A Review of Advanced Orthopaedic Clinical Practice" is meant to provide participants with a process of review. (It is not intended to satisfy examination criteria for the Orthopaedic Physical Therapy Competency Examination.) Cancellation received in writing prior to the start of the course date will be refunded minus a 20% administration fee. Absolutely no refunds will be given after the start of the course.

Objectives:

- Identify anatomical and biomechanical aspects of the foot, ankle, knee, hip, SIJ, and low back
- Know the pathology and pathophysiology for each region
- Describe advanced evaluation and treatment techniques for each area

Join the Section and take advantage of the discounted registration rate immediately!
For more information, or to register, complete the form below, detach and mail to:
Orthopaedic Section, APTA, 2920 East Avenue South, La Crosse, WI 54601, 800-444-3982.

NAME: _____

ADDRESS: _____

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☐ Yes, I want to take advantage of the member rate immediately. °(Please add $50 to your member rate fee).

Enclosed is my registration fee in the amount of $ _____
Please make checks payable to the Orthopaedic Section
☐ Orthopaedic Section Member
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MC/VISA: _____

Exp.: _____

☐ Check here if you have special needs that are regulated by the Americans with Disabilities Act.

Orthopaedic Physical Therapy Practice

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EDITOR'S NOTE

Guest Editorial

Early in my career, the goal that I set for my practice was for the majority of my patients to be referred specifically to me because of my reputation for providing exceptional care. I attained that goal and as a result, enjoyed tremendous satisfaction from my practice. Unfortunately, managed care has interfered with, and possibly destroyed, this goal. Referral sources—physicians, PTs, and other patients—can rarely direct patients to specific practices, and when referred, a patient's coverage is often insufficient to achieve reasonable outcomes.

I now have a new goal—for my practice to consist of patients who are referred specifically to me regardless of reimbursement restrictions. To do so, I will have to meet a new challenge of providing a service of sufficient value to patients that they are willing to pay out of their own pockets. Self pay—the ultimate challenge!

This may not be as hard as it seems—in fact the time is ripe! Patients are beginning to realize that insurance plans, particularly the heavily managed ones, may not provide all the services that they need or want. At the same time, because of reductions in reimbursement and increases in operating costs, many centers have responded by increasing the volume of patients and decreasing contact time between PTs and patients. Many patients want care that extends beyond their insurance benefits and are requesting alternatives to high volume centers.

There are several barriers to attaining this goal. Patients are accustomed to being reimbursed for traditional medical services, including physical therapy, and don't often recognize the value of one provider over another. In fact, it is common for patients to switch providers for a co-payment difference of five dollars!

Additionally, I wonder if we haven't priced ourselves out of the self-pay market. Everyone is aware of how PT charges have skyrocketed in the past five years. Are our services really worth what we charge? Other barriers include lack of direct access in some states and poor recognition by the public of the physical therapists' role in nontraditional settings such as golf and performing arts.

To move into the self pay arena, we have a lot of work to do. First of all, we must be constantly aware of providing outstanding service—we must be the best! We must accept responsibility for the ongoing development of excellent clinical skills—regardless of limited education funds from employers. We must realize—and actually calculate—the value of our time with our patients (probably three to four dollars a minute!) and make each minute count.

We must constantly be aware of our patients' goals, reassess our patients throughout each treatment session, and modify our treatment according to these responses. We must appropriately delegate the portions of treatment that do not require our expertise so that our time with patients is spent on education, hands on care, and activities involving critical decision making. Our fees should be fair and should reflect the most highly skilled aspects of the care we give instead of passive modalities and nonspecific exercise.

We must let the public know of our skills in nontraditional settings. Involvement in community events, volunteer clinics, health fairs and public speaking is critical. Patients with limited insurance coverage or with chronic problems requiring periodic PT management need education regarding self-pay as an option. Absence of direct access, although a hassle, should not be a barrier as long as the referral source is assured that the referral to treat is separate from the authorization to pay.

Most importantly, we must ask ourselves honestly whether our practices could survive without insurance reimbursement and whether we would pay out of our pockets for services we provide.

Nancy White, MS, PT is Vice President of the Orthopaedic Section.

Nancy White, MS, PT

President's Report

Joint Manipulation A Sacrificial Lamb?

During the Component Presidents Meeting held June 12, 1996 at the Physical Therapy '96: APTA Scientific Meeting and Exposition, a discussion ensued related to state licensure issues. One bit of information shared with the group was that the South Dakota Physical Therapy Association recently gave up the ability to perform joint manipulation in order to gain legislative support from the chiropractic association. The therapists can still perform joint mobilization, but will not be allowed to manipulate. Compromise is a political fact of life and I am not aware of all of the events that led to this particular compromise, but the fact that joint manipulation has been sacrificed legislatively in the past makes this most recent event very troubling.

Why has joint manipulation become a sacrificial lamb for some states in their quest for practice act changes including direct access? The obvious answer is that chiropractic associations can be powerful allies and may make the difference between a legislative bill passing as opposed to being defeated. The rationale for giving up joint manipulation is typically, "only a few therapists perform this particular intervention and direct access will benefit a majority." If this rationale is acceptable, then maybe we should also give up the right to perform electrodiagnostic testing to win the support of neurologists and physiatrists and then we can give up the right to fabricate orthotics to win the support of podiatrists. We are kidding ourselves if we think the chiropractic associations will be satisfied with just prohibiting physical therapists from performing joint manipulation. They want to be THE primary providers of conservative care for all orthopaedic patients. Can a skilled orthopaedic manual therapist successfully treat a majority of the patients presenting with mechanical dysfunction without utilizing a high velocity thrust technique? Of course, but by giving the chiropractors exclusive rights to joint manipulation we strengthen their position in the health care arena at our expense, making it more difficult for all physical therapists to compete with them on the open market.

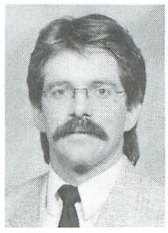
The purpose of this message is not just to cast stones on those states that have given up joint manipulation, because I believe the Orthopaedic Section is also responsible in part. Could we have prevented South Dakota from giving up joint manipulation if the Section had provided education regarding the short and long term implications of such action, alternative and more acceptable language found in other state practice acts (i.e., Minnesota—"physical therapists will not perform *chiropractic* manipulation" which means as long as the therapist uses a manipulative technique found in a non-chiropractic reference they stay within their scope of practice) and, literature which refutes many of the claims chiropractors typically make against us? Unfortunately, we'll never know regarding South Dakota, but we are working hard with the American Academy of Orthopaedic Manipulative Physical Therapists (AAOMPT) to minimize the chances of this type of compromise ever happening again. We are accumulating a library of information related to chiropractic legislative issues. Annually, a listing of what we have catalogued will be sent to each of the 50 state association offices (See Director, Elaine Rosen's report). We are also coordinating efforts with APTA to provide states with whatever information necessary regarding this issue. We are committed to being a readily available resource to the state associations.

PT/PTA RC (Arizona/PPS)

The Section Board of Directors developed a task force consisting of Mike Cibulka, Scott Stephens and Carol Jo Tichenor to contact a number of physical therapists and physical therapist assistants to get opinions on where they stood on this issue. There was a uniform lack of support for the RC as written mainly due to the soft tissue component. The Orthopaedic Section Board of Directors voted not to co-sponsor this RC with the Arizona Chapter and the Private Practice Section. The efforts of the task force were greatly appreciated. This RC was pulled from the floor of the HOD prior to debate and therefore was not voted upon.

Bill Fromherz

It is with sadness that I report the death of Bill Fromherz. Bill was the Section Secretary from 1983-87 and the Member-at-Large 1987-89. He played an important role in the evolution of the Orthopaedic Section. Our condolences go out to Bill's family.



William Boissonnault, MS, PT
President

From the Section Office

Terri A. Pericak, Executive Director

Thanks to Tara Fredrickson, our computer support person in the Section office and Steve Greene, our computer technician, I am pleased to announce that the Section office is now on the Internet. Thanks also to our Director, Mike Cibulka, the Section now has its own home page. Following are addresses for both:

E-mail: orthostaff@centuryinter.net
Home Page: www.orthopt.org

The Section is very pleased to be able to provide you with access to our services through the Internet. I encourage you to communicate with both the Section office and Section officers through e-mail as well as check on the current and upcoming educational courses through our home page.

The Finance Committee is meeting this month at the Section office in La Crosse, Wisconsin, to finalize the proposed budget for 1997 which will be presented to the Board at their meeting in October. Reports from the Section's investment brokers, accountant and auditor will be heard and recommendations discussed. A summary of the meeting will be written up in the November issue of *OP*.

A National Grand Opening for the Section's new office building and professional park will be held in conjunction with the October Board of Directors meeting in La Crosse. A special dedication of the conference room in Jim Gould's memory will be held. The dedication will include a presentation of Jim's life on CD ROM which was created by Bob Burles, a long time Section member and good friend of Jim's. This will prove to be a very special and memorable event.

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Danielle Benzing, Publications Secretary
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Orthopaedic Physical Therapy Practice (OP) Survey

Do you read *OP* on a regular basis? Yes No

Is *OP* meeting your needs? Yes No

Is the information offered in *OP* relevant and clinically applicable? Yes No

Currently *OP* is published 4x/year; do you prefer 6x/year? Yes No

Suggestions for *OP* include: _____

Thank you for your input!
Please FAX to 608-788-3965 or
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The Orthopaedic Section, APTA, Inc., would like to congratulate all of the following individuals who have recently become Orthopaedic Certified Specialists:

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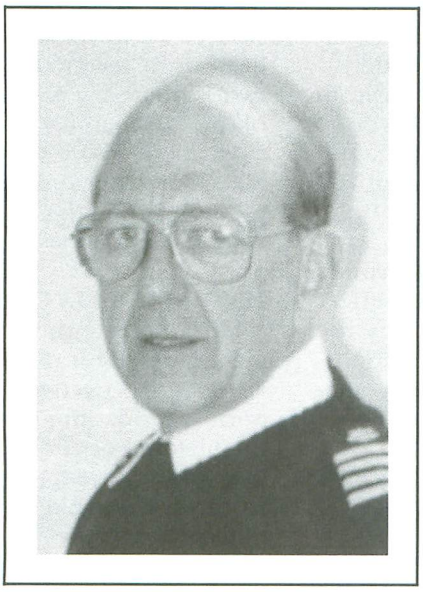
In Memoriam
Bill Fromherz



Bill Fromherz passed away on June 8, 1996. Bill was born and raised in Lebenon, Oregon and graduated from Oregon State University in 1965. He attended Stanford University School of physical therapy and held a masters degree from Emory University.

Bill began a career in the U.S. Public Health Service in San Francisco upon graduation. His career in the USPHS included work at Carrville in Louisiana, the NIH gait lab in Maryland and finally as Chief Staffing Section and Deputy Chief Officer, Development Branch. Bill was active with the APTA and held elective offices including District and Chapter President in California and Louisiana. Bill served as Secretary from 1983-1987 and Member-at-Large from 1987-1989 of the Orthopaedic Section.

Bill is survived by his wife, Kathy who continues to be active in physical therapy and two children, Chris, an engineer and Erica who will be entering college next year.

Bill's passing is our loss and he will be sadly missed.

Bob Burles

The Blake Inverted Orthotic: An Overview

By Stephen P. Baitch, PT

This article was submitted by the Foot and Ankle Special Interest Group.

For the past several decades, orthotic devices have been successfully used to treat a myriad of lower extremity pathologies related to the foot. There is also much literature to support the use of orthotic devices and their relatively high success rate of approximately 75 to 85 percent, in regards to the alleviation of symptoms. However, we as clinicians should also be concerned with the 15 to 25 percent failure rate of orthotic devices, especially in the age of the managed care and critical pathways environment. Even more importantly, we must consider the implications of orthotic failure for the patient who is attempting to return to a pain free environment while performing in sports or everyday walking. In some cases, success or failure of the orthotic devices may mean the differences between surgical and nonsurgical intervention.

In the late 1980's this ongoing percentage of orthotic failure gave rise to the emergence of the Blake Inverted Orthotic Device, developed by Dr. Richard Blake, a podiatrist in San Francisco, California. Dr. Blake's development of his inverted technique stemmed from the frustration of treating thousands of runners with conventional orthotic techniques, only to have a certain percentage of these runners continue to complain of symptoms, regardless of posting or material modifications made to the orthotic devices.

As a result, he initiated the fabrication of an orthotic device using a radical inverted technique in order to control abnormal motion of the foot, which he believed to be the cause of the failure of many orthotic devices to alleviate symptoms.

INDICATIONS FOR THE BLAKE INVERTED ORTHOTIC

An inverted orthosis is primarily used when a standard root functional orthotic fails to control abnormal subtalar and or midtarsal joint pronation and thus is unable to alleviate symptoms. There are some relatively specific criteria than can be utilized from a biomechanical standpoint when evaluating whether or not a patient is a candidate for inverted orthotic devices. These criteria include:

1. a resting calcaneal stance position (RCSP) of greater than 5° everted
2. a tibial varum greater than 8-10°
3. a forefoot varus of greater than 10°
4. severe midtarsal joint pronation

These are a few of the basic criteria the practitioner can use to determine if an inverted orthotic may be effective in a particular case whereby the patient's symptoms as well as abnormal pronation have not been adequately addressed.

MAJOR DIFFERENCES BETWEEN THE ROOT FUNCTIONAL AND BLAKE INVERTED ORTHOTIC

Most negative casts for the root functional orthotic are poured to a perpendicular position by balancing the forefoot on the rearfoot, by the orthotic lab. The negative cast for the Blake Inverted Orthotic, however, is poured in varying degrees of inversion, ranging from 15 to 65° inverted from the perpendicular position.

> We as clinicians should also be concerned with the 15 to 25 percent failure rate of orthotic devices, especially in the age of the managed care and critical pathways environment.

RATIONALE FOR PRESCRIPTION WRITING

In general, the greater the degree of abnormal pronation noted, the greater the degree of inversion prescribed for the inverted orthotic. The RCSP is probably the most suitable criteria for determining the pouring position of the negative cast. This is based on the hypothesis developed by Blake which states that for every 5° the cast is poured inverted, a 1° change is reflected in the RCSP toward the inverted side of vertical. For example, if the RCSP is 5° everted and the negative cast is poured at a 25 angle, the RCSP of the calcaneous would change from a 5° everted to a 0° position, when placed in the orthotic device. Clinically, I have found this hypothesis to hold true in many cases.

MATERIAL SELECTION

Most often, the more rigid the material used for the Inverted Orthotic, the more effective the control of abnormal pronation. Carbon graphite is the material of choice in many cases, due to its strength and durability. However, it should be noted that high density polypropylenes are also utilized.

PATHOLOGIES SUCCESSFULLY TREATED USING THE INVERTED ORTHOTIC

Lower extremity problems that have responded well to the Inverted Orthotic technique include:

1. sesamoiditis
2. posterior tibial tendonitis
3. medial tibial stress syndrome (shin splints)
4. sinus tarsi syndrome
5. patella-femoral syndrome

The practitioner must keep in mind that the aforementioned pathologies have been unsuccessfully addressed with conventional orthotic techniques prior to implementation of the inverted orthotic.

COMPLICATIONS OF THE INVERTED ORTHOTIC

Complication of the inverted technique may include general intolerance, lateral ankle instability or lateral symptoms involving the fifth metatarsal, iliotibila band or other lateral structures. In my experience, however, complications resulting from the inverted orthotic have been minimal.

DISCUSSION

The inverted orthotic technique has been successfully implemented with several hundred patients in our Sports Medicine as well as our Foot and Ankle Center over the past seven years. Initially, the technique was applied exclusively to our running population, however, over the past four years, patients who suffer from lower extremity problems secondary to everyday walking have also benefited from the inverted orthotic technique.

There are many questions to be answered regarding the efficacy and long term effects of the inverted orthotic technique and these issues surely deserve careful scrutiny. However, until these issues are resolved, we as clinicians must continue to search for new avenues of treatment when traditional methods fail. I feel that the inverted orthotic technique has helped to bridge the gap between failure and success for myself and my colleagues, but more importantly, for our patients.

Stephen Baitch is a member of the Foot and Ankle Special Interest Group and works at the Sports Medicine as well as our Foot and Ankle Center at the Union Memorial Hospital in Baltimore, Maryland.

Space limitations do not allow us to print the following lists:

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If you are interested in obtaining any of the above information, please contact us at 800/444-3982 and we will gladly mail or FAX the list to you.

A Million Dollar Dream

Single largest gift to UW-L Foundation has humble beginnings

This article was reprinted with permission from the Spring '96 issue of Alumnus.

Rich Polek had a dream to establish a scholarship as a memorial to his wife taken by cancer at age 35.

The late professor Jim Gould had a dream that university students seeking a physical therapy (PT) degree—especially those with financial need—could receive financial help for their education.

Polek's neighbor, Ernest "Ernie" Matejaitis, dreamed most of his estate would go to a deserving charity so the government wouldn't reap estate taxes from money on which he had already paid income taxes.

Their dreams have become realities in a $1 million endowment from Matejaitis to the UW-La Crosse Foundation. Beginning in 1996-97, PT students at UW-L will receive achievement, clinical internship and thesis scholarships from the estimated annual $50,000 endowment earnings.

Donation, brochure from UW-L professor set the groundwork

The story of the largest single gift ever to the UW-L Foundation has humble beginnings stretching back to November, 1992. Rich Polek wanted a lasting memorial for his wife, Cindi Stoller Polek, who graduated from UW-L's prestigious PT program in 1981. After Cindi

> The late professor Jim Gould had a dream that university students seeking a physical therapy (PT) degree—especially those with financial need—could receive financial help for their education.

died at the age of 35 following a brief bout with cancer, one of her co-workers suggested Rich Polek establish a scholarship at Good Shepherd Hospital in Barrington, Ill., where Cindi worked. According to hospital policies at the time, the scholarship fund wasn't large enough for an endowment. While considering how to proceed with the fund, Polek remembered a brochure sent with a memorial gift from one of Cindi's former teachers, Jim Gould.

The brochure outlined UW-La Crosse Foundation funds, noting that only $5,000 was needed to initiate a perpetually endowed scholarship. Polek, who had already collected more than $15,000 from friends and relatives, met with Gould and UW-L Foundation Gift Planning official Al Trapp. Polek liked what he heard and eventually transferred the donations to UW-L where he knew he could endow the scholarship.

"I knew I could trust the Foundation at Cindi's alma mater to faithfully operate the scholarship according to my wishes," Polek says.

Polek continued to ask friends, relatives and neighbors for contributions to the scholarship so it could be endowed large enough to generate annual earnings between $2,000-$3,000. That's where neighbor "Ernie" entered the picture.

Front stoop conversation initiates gift

Ernest "Ernie" Matejaitis became Rich and Cindi Polek's neighbor when they moved to Lindenhurst, Ill., a suburb north of Chicago. Matejaitis could have been described as a cast member from the movie "Grumpy Old Men."

"He was unassuming and remarkable for his worn attire, lack of socks, often unshaven face, and three dogs on leashes as he walked around the block," remembers Polek. "Ernie befriended anyone who accepted him at face value."

Living next door, the Poleks became more than across-the-fence-neighbors to the loner Matejaitis, who felt he could never help enough with his neighbor's repair projects. "Cindi made a huge impression on him," explains Polek. "She was such an attentive listener, always responding with great sensitivity. She made the other person feel like they were the most important person in the world. That made a big impact on Ernie and almost everyone she knew."

Like his immigrant father, Matejaitis worked at U.S. Steel and Wire until retiring in 1980 with 38 years of service. He never married and liked to teasingly boast about his investments. "He told his neighbors that his hobby was money," recalls Polek.

One day Polek and Matejaitis, who usually talked business, began discussing wills and estates. Polek pointed out to Matejaitis that if he didn't have a will, the government would decide where his money would go, after it taxed his money—for the second time—before it went to beneficiaries.

Matejaitis—who had pulled his U.S. flagpole from his front lawn after a disagreement with the government—didn't want the second tax. An alternative was to give most of estate to charity.

After hiring an attorney and writing a will, Matejaitis told Polek he had named Cindi's UW-L Foundation Endowment as one of several beneficiaries. Polek, however, didn't know it was the primary benefactor until the will was read after Matejaitis died of prostate cancer May 27, 1995. Later in the year, the estate gave $1 million to the endowment.

"This all started on the front stoop of my house," notes Polek. "I'm humbled by what we're going to be able to do."

Scholarships to "touch many"

The $1 million gift, along with $28,000 already in the endowment allows the Cindy Polek scholarship to expand significantly. Now the endowment will fund:

- The Cindi Stoller Polek Achievement Scholarships, which will pay full or partial tuition to numerous PT students.
- The Cindi Stoller Polek/Ernest R. Matejaitis Clinical Internship Scholarships, which will pay full or partial expenses to PT students doing clinical internships.
- The Cindi Stoller Polek/James A. Gould Thesis Scholarships, which will fund full or partial expenses to PT students completing theses.
- A PT student from Illinois qualifying for one of the above awards can be named The Ernest R. Matejaitis Illinois Scholar in Physical Therapy.

Matejaitis didn't aspire to have his name in a scholarship. But, Rich Polek believes it's important for Matejaitis' memory to live on with future generations. "By his extraordinary financial means and generosity, Ernie has made dreams come true," says Polek. "It's important to include his name in the memorial, although he would have been embarrassed by all the fuss."

"With the expanded scholarships, many more students will come to know not only the young physical therapist who flashed her bright blue eyes and heartwarming smile to patients, but also two special people in her life—Jim Gould, her former professor, and Ernie Matejaitis, her crusty, old neighbor with a heart of a teddy bear."

Rich Polek remarried in October, 1994. His wife, the former Jennifer Woleben of Elgin, Ill., became Matejaitis' new neighbor and developed a friendship. Matejaitis didn't shy away from sharing stories about Cindi. And when his illness took hold, Jennifer didn't shy away from asking him some eternal questions.

Jennifer believes the humble Matejaitis' main concern was remembering his special former neighbor. "Ernie knew what he left in Cindi's memory," explains Jennifer. Matejaitis liked to focus on his "red-haired angel with the squeaky voice" when talking about spirituality, she says. "He believed that Cindi's soul was going to be the first he'd encounter in the next life," she recalls.

Rich Polek originally established the scholarship in Cindi's name so others could come to know the "young woman who brought a red-headed fire of enthusiasm to her work as a physical therapist," but the $1 million gift changes that. With the expanded scholarships, many more students will come to know not only the young physical therapist who flashed her bright blue eyes and heartwarming smile to patients, but also two special people in her life—Jim Gould, her former professor, and Ernie Matejaitis, her crusty, old neighbor with a heart of a teddy bear.

Rich Polek has met Cindi's scholarship recipients, and plans to meet many of them in the future. But he wishes Jim Gould, who died of cancer in August 1995, was still alive to see his dream of funding scholarships to PT students come true. Even though Cindi and her friends are dead, Polek says their impact isn't. "Cindi, Ernie and Jim are role models to me," he explains.

UW-L Chancellor Judith Kuipers says the gift means a great deal, not only to physical therapy students, but also the university. "The many students receiving the scholarships will come to know Cindi as a role model for her efforts in improving the lives of others," says Kuipers. The $1 million endowment will be a key element in the new La Crosse Medical Health Science Consortium, in which UW-L has teamed up with the city's other colleges and medical organizations to provide much needed primary care training for the tri-state area.

Polek says the unfortunate experience of losing a beloved spouse—along with discovering how much his wife impacted others—has given him a different outlook on life, helping him grow spiritually.

"No matter how bad things can become, there is good that can come from it," says Polek. "Now she'll be touching many."

Book Reviews and Abstracts

Coordinated by Michael Wooden, MS, PT, OCS

BOOK REVIEWS

Jones K, Barker K: Human Movement Explained. 1996 Butterworth-Heinemann, Oxford, 416 pp, soft cover, illustrated.

Part of a series led by *Physical Therapy Explained* and *Physical Principles Explained*, this text from a lecturer in the Department of Physiotherapy Studies at Keele University, Staffordshire, UK and an experienced clinician from Nuffield Orthopaedic Centre NHS Trust, Oxford, UK brings the multiplicity of movement science into a single, readable text.

The stated goal of the authors is to provide a "complete introductory text for movement studies" for the undergraduate in the allied professions. The text is divided into biomechanical principles, principles and types of exercise, and locomotion and ergonomics. Each chapter is well referenced. The bibliography includes the cited pages within each publication.

This evaluation comes from the perspective of a long-term generalist in physical therapy. No doubt another view from an educator may provide a different slant. Rehabilitation colleagues in the UK may also have another perspective.

While easy to read, a lack of background and depth in some of the more complex areas, such as neurophysiology, required frequent re-reading to get a reasonable picture of what the authors were trying to convey. The effect may leave the novice unable to fit the information into a relevant context.

Osteokinematics and arthrokinematics are ably explained for the novice level. Other areas seem oversimplified to the point of confusion. The explanation of oxygen uptake theory is an example as is the explanation of balance theory.

Interesting, too, is the choice by the authors of where to go into more depth on a subject. Indeed, such definitive programs as group exercise sessions for patients with Colles fracture, point out significant cultural differences in health care systems between the UK and the USA.

Overall, the text could be a good refresher for the clinician returning to the field. It could be valuable as a quick reference for clinicians whose education predates the current state of knowledge in neurophysiology and other principles which underlie rehabilitation practice today.

Jill Floberg, PT

The Thoracic Spine and Rib Cage: Musculoskeletal Evaluation and Treatment. Flynn TW. 1995, Butterworth-Heinemann. Boston, MA, 336 pp, hardcover.

The purpose of this text was to provide the health care practitioner with a reference to use when evaluating the thoracic spine and the rib cage for injury or dysfunction. The book was divided into four sections that allow the reader to progress systematically through a sequential thought process similar to that required when examining a patient with thoracic pain.

The first section thoroughly reviewed the anatomy, biomechanics and neurophysiology of the thoracic region. In the second section, examination and differential diagnostic procedures were covered. Brian Demby, MD covered radiology and imaging of the thoracic spine. Clinical electrophysiologic testing was presented by Frank Underwood, MPT, ECS, PhD. Mary Reid, MD then focused on the bone trauma and disease and Wade Lillegard, MD covered the medical causes of pain throughout the thoracic area. To conclude the evaluation process, John Halle, PhD, MPT discussed the neuromusculoskeletal scan examination and Mark Bookhout, MS, PT detailed the biomechanical evaluation process used to detect the presence of somatic dysfunction and determine its significance to the patient's complaint.

Treatment was the focus of the third section. Flynn summarized muscle energy techniques, mobilization and high velocity thrust procedures for all levels of the thoracic spine and ribs. Then, Jeffrey Ellis, PT, MTC and Gregory Johnson, PT covered myofascial assessment and treatment considerations. Injection techniques were presented by Thomas Szulc, MD, Beate Carriere, PT demonstrated many therapeutic exercise and self-correction programs. The fourth section discussed how to clinically integrate a comprehensive evaluation and treatment program of the thoracic area from an osteopathic perspective. Mark Tomski, MD summarized the management of pain and dysfunction into one word, "goals." Those goals must be set and shared by both the patient and the health care practitioner.

The 15 contributing authors represented a multidisciplinary group of physical therapists, doctors of osteopathy and medical doctors with a variety of backgrounds related to the evaluation and treatment of the thoracic region. Timothy Flynn, PT, MS, OCS editor and contributing author is an Instructor of Continuing Medical Education, College of Osteopathic Medicine in Michigan and is a Doctoral Candidate at Pennsylvania State University.

This text will definitely fill a void in the present musculoskeletal literature and be helpful to both the novice and experienced practitioner. Having taught the thoracic and rib area to physical therapy students in the past, I was well aware of the lack of a comprehensive book related to the thoracic spine and consequently see this as a useful reference for our profession.

Edie Knowlton Benner, MA, PT, OCS

Sports Medicine and Rehabilitation: A Sport-Specific Approach. Buschbacher R, Braddom R (eds), Philadelphia, PA: Hanley & Belfus, Inc., 1994, 319 pp, hardcover, illus, $45.00.

This textbook offers the reader an intriguing approach to sports medicine and rehabilitation, with easy-reference sport-specific chapters. The twenty-eight (mostly physician) authors are well-respected medical authorities in the sports medicine field. Being a book with a title including rehabilitation, surprisingly, only one physical therapist contributed. However, there

are several references to publications done by PTs.

The text includes twenty-two chapters that vary significantly in rehabilitation content. The three chapters that provide the reader with the most in-depth rehabilitative information are "The Rehabilitation of Throwing and Racquet Sport Injuries" (contributed to by a PT), "Swimming Injuries," and "Alpine Skiing." There are a few chapters with helpful illustrations showing proper positioning for exercises, schematic drawings, phases of movement, and informative tables for quick reference. These include "Tissue Injury and Healing," "Swimming Injuries," "Issues in Gymnasts and Dancers," and "Ankle Sprain Evaluation and Bracing." In addition, the following chapters are not sport-specific but very informative: "Knee Bracing," "Pediatric Sport Issues," "The Active Woman," and "The Wheel-Chair Athlete" to name a few. The reader could have benefited from a chapter on orthoses, which were virtually excluded.

Two of the more complete chapters are "Prevention and Treatment of Bicycle Injuries" and "Body-Building and Weight-Lifting." The chapter on cycling contains types of bikes, safety, prevention of injury, common injuries, and informative appendices of literature/videos that the reader could obtain. The body-building/weight-lifting chapter includes physiology, prevention of injury, illustrations, common injuries covering both the spine and extremities, and the discussion of steroids.

In summary, although the lack of PT contributors is disappointing, I would recommend this book for the experienced clinician who sees a sports medicine patient population. It is a convenient reference for treating an athlete with a typical sport-specific injury. Entry level practitioners may need time getting comfortable with protocols and the more functional approach taken with athletes, prior to reading this text.

Cory Tovin, PT

ABSTRACTS

Muscular Adaptation to Concentric and Eccentric Exercise at Equal Power Levels. Mayhew TP, Rothstein JM, Finucane SD, et al. Virginia Commonwealth University, Medical College of Virginia, Department of Physical Therapy, Richmond, Virginia, Med Sci Sports Exerc 1995;27:868-873.

The purpose of this study was to determine if differences in the fiber area of the vastus lateralis muscle would occur as a result of concentric and eccentric isokinetic exercise at equal power levels (torque x angular velocity). A second purpose was to determine if differences in maximal isometric torque of the quadriceps femoris muscle would occur as a result of concentric and eccentric isokinetic exercise at equal power levels.

Twenty healthy volunteers were randomly divided into two groups. One group performed five sets of ten concentric quadriceps femoris muscle contractions three times a week for four weeks and the other group performed an identical number of eccentric contractions. Both groups exercised at the same relative power level: 90% of the maximal power produced during a preexercise concentric test. Needle biopsies of each subject's right vastus lateralis muscle and measurements of each subject's maximal isometric right quadriceps femoris torque were taken before and after the exercise training sessions. Analysis of covariance (ANCOVA) tests were used to determine differences between the two groups in postexercise fiber area and postexercise maximal isometric torque while controlling for initial discrepancies due to gender differences between the two groups.

Results demonstrated significantly greater area of Type II fibers and greater maximal isometric torque production in the concentrically trained group compared to the eccentrically trained group. There were no differences between the two groups in the areas of Type I fibers.

The authors conclude that when training at similar power levels, concentric contractions may be more effective in producing both fiber hypertrophy and improvement of isometric torque than eccentric contractions.

Marie Johanson, PT

Patellar Taping: A radiographic examination of the medial glide technique. Laren B, Andreasen E, Urfer A, Michelson M, Newhouse K. Am J Sports Med 23(4):465-471, 1995.

The purpose of this study was to examine radiographically the effects of the McConnell medial glide taping technique. Subjects were 20 healthy males, ages 18-35. Bilateral knee radiographs, using a modified Merchant view in partial weightbearing, established baseline patellar positions. Differences between subjects' knees were not significant, allowing one's knee to serve as a control. Experimental knees were then taped by an investigator trained in the McConnell technique. The intent was to medially glide the patella a percent of each subject's patellar width. Following taping the radiographs were repeated. Subjects then participated in a standardized 15 minute exercise program designed to stress the tape and to simulate athletic movement. Radiographs were repeated a third time following exercise. Comparisons of baseline and post-taping radiographs indicated significant differences ($P = .003$), with the patella moved medially a mean of 9 degrees. The authors noted, however, that taping was ineffective in moving the patella any degree in 3 subjects (15%). After-exercise radiographs showed no significant differences when compared to baseline, indicating the tape was ineffective in maintaining the medial patellar position. Exercise resulted in significant lateral shift ($P = .016$) in the control knees only, suggesting that medial taping may prevent excessive lateral shift during exercise.

Sandi Smith, PT

The Effects of Spinal Flexion and Extension Exercises and their Associated Postures in Patients with Acute Low Back Pain. Dettori JR, Bullock SH, and Sutlive TG, et al. Spine 1995;20:2303-2312.

This study compared the effects of spinal flexion or extension exercises and their postures with a control group of no exercise or posture instruction. The comparison was based on functional status, spinal mobility, straight leg raise, pain severity, and treatment satisfaction of active duty soldiers with acute low back pain. Also, it was determined if either form of exercise and posture, or a combination of the two, reduced recurrent episodes of low back pain.

One hundred and forty-nine Army, active-duty personnel, with acute low back pain, were randomly assigned to one of five subgroups; flexion exercises—flexion posture, flexion exercises—extension posture, extension exercises—extension posture, extension exercises—flexion posture and a control group. A later group was added—extension exercise, extension posture, and flexion exercise. Outcomes were

measured at 1, 2, 4, and 8 weeks. A follow-up questionnaire was used six to twelve months later to assess reoccurrence of low back pain. Three therapists measured functional outcomes using the Roland self-administered functional disability instrument and the subject's ability to return to full work. Pain level was assessed on a 6-point scale and spinal mobility with flexible tape measure. Goniometric measurement was used to measure hip flexion angle of the straight leg raise.

Results of this study indicate that flexion and extension exercise groups did not differ in any outcome over eight weeks. After one week, patients that received flexion and extension exercises and posture instruction returned to work and had less functional disability compared to the controlled group of no exercise or postural instruction. After one week, patients recovered at similar rates, whether or not they performed exercises. Back flexion or extension exercises in treating acute low back pain do not affect the rate of reoccurrence of low back pain six to twelve months later; although patients who receive back extension exercises may have a better recovery in terms of less frequent medical visits or work limitations.

Jennifer Ryan, MS, PT, OCS

FYI

The Orthopaedic Section will not offer refunds on purchased promotional items once the items have been mailed out of the Section office. If the items arrive damaged or are defective, notify the Section office immediately so arrangements can be made for an exchange.

Section Members in the News

Sean P. Gallagher, PT and his associate Gina Giammanco, PT performed together a dance piece based on what they do on a daily basis. The dance was choreographed during the David Parsons Dance company's New York season. Sean is an Orthopaedic Section member and past President of the Performing Arts SIG.

❖

Congratulations to Joe Farrell, PT, Orthopaedic Section member and President of the American Academy of Manual Physical Therapists for being elected to the Executive Committee of the International Federation of Manual Therapists (IFOMT). Joe was elected at the April '96 IFOMT Conference held in Lillehammer, Norway.

❖

William Pesanelli, PT was named Director of the Sargent Clinic at Boston University. The clinic provides comprehensive outpatient rehabilitation services. Congratulations.

❖

Congratulations to Richard Bohannon, EdD, NCS, PT for receiving the Helen J. Hislop Award for Outstanding Contributions to the Professional Literature.

❖

Congratulations to Jane Hogencamp, MS, PT for receiving the Lucy Blair Service Award.

❖

Congratulations to Kathryn E. Roach, PhD, PT for receiving the Eugene Michels New Investigator Award.

❖

Congratulations to the following Orthopaedic Section Members who received certification in other specialty areas:

Daniel Ciolek, MS, PT, GCS
Cynthia Driskell, PT, GCS
Martha Giddes, PT, GCS
Kari Fields, PT, GCS
Nora Gilligan-Havens, PT, NCS
John Jankoski, MPT, NCS
Kevin Krause, PT, SCS
Joyce Lckart, MS, PT, OCS, SCS
Michael McCormack, MHS, PT, SCS
Bobby Perkins, PT, SCS
Brian Tovin, MMSc, PT, SCS
Michele Weinstein, MS,PT, SCS
Renee Rowley, PT, PCS
Mary Stephens, MS, PCS

❖

If you know of a Section Member in the News, please contact Sharon Klinski at the Section office. 800/444-3982 or FAX 608/788-3965 or e-mail orthostaff@centuryinter.net

Don't Let Election-Year Tax Talk Distract from Your Investment Goals

By Fred Fletcher

It looks like we all survived yet another April 15, even if our wallets are a lot lighter. Now that the trauma of the annual spring ritual is behind us, we should be able to start thinking about something else besides the tax load (which forces most Americans in effect to work until May 8 before they can stop paying the tax man and begin paying themselves).

Unfortunately, it's an election year and you can bet the tax reform talk we've all heard over the past year will reach a fevered pitch between now and November. And it's easy to understand why. Tax reform is a staple of political campaigns and many an election has been won or lost on voter reaction to one proposal or another. This year is different only in that the discussion is focusing on a variety of "flat tax" proposals. Republican presidential hopeful Steve Forbes and several candidates milked the issue for all it was worth during the primaries before the glare of media scrutiny allowed Americans to take a much harder look.

On its face, a flat tax looks great! Most of the proposals called for a uniform tax rate of between 16 and 20 percent for all taxpayers for about the first $35,000 of income, but allowed virtually no deductions. That compares with tax rates that currently range up to 39 percent of adjusted gross income and a CPA-baffling maze of deductions.

The flat tax looked so simple and so powerful, it caused a frenzy across the nation. Candidates scrambled to make sure they could offer their own version. Gradually, some of the downside of a flat tax began to emerge, not the least of which was that some proposals called for elimination of sacred deductions, including that for mortgage interest, one of middle America's last remaining tax breaks.

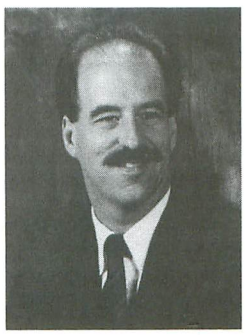
While the commotion over the flat tax has died down a bit, expect it to be cranked up again in the months to come. And realize, that the good of a flat tax probably outweighs the bad, especially if mortgage and charitable deductions are retained.

Because of those in the higher level tax brackets, the flat tax could considerably reduce the government's bite. One of the most significant advantages of most proposals is that there would be no tax at all on investment income.

The thing to remember is not to get too caught up in the hype surrounding any tax reform proposal, flat, VAT, USA, or any other. That's because it's mostly election year rhetoric and the chances of significant reform occurring any time soon are slim at best.

No matter what happens, there are steps you can take now to minimize your exposure under today's laws. The key is to make sure you have a long-range investment strategy that takes into account your goals, whether it's saving for your children's college education, planning your own retirement or getting ready to prepare your estate. Those goals will dictate what strategies you can use to reduce taxes, whether it's investing in tax-deferred, tax-free, or other tax-advantaged investments.

By working with a trusted financial professional—who knows your circumstances and understands your objectives—you have the best chance of reaching those goals within an investment plan that puts the maximum number of dollars in your pocket and the least possible in Uncle Sam's. You'll never enjoy April 15, but you may be able to avoid dreading it.



Fred Fletcher is an Investment Executive who provides investment advice to the Orthopaedic Section, APTA.

If you would like additional information, please contact Fred through the Orthopaedic Section office.

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.

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 funds may be used to purchase equipment, pay consultation fees, recruit patients, or clinicians. Clinicians receiving funding from this program will be expected to present their results at CSM within 3 years of receiving funding.

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
- Principal investigator (PI) must be an Orthopaedic Section member
- Priority given to projects that are currently not receiving funding
- The funding period will be one year

Criteria for Funding: Type II 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 (IRB) approval from participating site(s), and letter of support from facility(ies) participating in the study
- Evidence of some pilot work
- Principal investigator (PI) must be an Orthopaedic Section member
- Priority given to projects that are currently not receiving funding
- The funding period will be one year, renewable for up to three years, if judged to be appropriate

Determination of the Awards: **Deadline for submission of grant proposals is **December 1, 1996.** 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, 1997.

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

1997 CSM TENTATIVE PROGRAM — February 13-16 — Dallas, TX

WEDNESDAY, FEBRUARY 12
8:00 AM-6:00 PM
Foot Orthoses: The Scientific Basis and Clinical Concepts

8:00 AM-5:00 PM
Orthopaedic Specialty Council: Item Writer's Workshop

THURSDAY, FEBRUARY 13
8:00 AM-12:00 PM
Multi-Section Programming: Diagnosis

1:00 PM-3:00 PM
Cowboy Up! Injuries of Rodeo Athletes
Speaker: Tandy R. Freeman, MD
Moderator: Kim Schoensee, MS, PT, OCS

1:00 PM-2:30 PM
Occupational Health SIG Programming
Evaluation of Permanent Lumbar Impairment: The Physical Therapy Perspective
Raymond Vigil, PT, OCS
Moderator: Gwen Parrott, PT

1:00 PM-4:00 PM
Research Platforms

4:30 PM-6:30 PM
EXHIBIT HALL BREAK

6:30 PM-7:30 PM
Performing Arts Reception

FRIDAY, FEBRUARY 14
(Board and Committee Chair Meeting)

8:00 AM-10:00 AM
Pain SIG Programming
Industrial Testing: Pain Prevention
Speakers: Joseph Kleinkort, PhD, PT
Tom Watson, MEd, PT, FAAPM
Moderator: Gaetano Scotese, MPT

11:00 AM-12:00 PM
Pain SIG Business Meeting

8:00 AM-10:00 AM & 11:00 AM-12:00 PM
Research Platforms

8:00 AM-10:00 AM
Treatment Guidelines: Moving in the Future
Carol Schunk, PT, PsyD
Joint Programming with Private Practice Section

8:00 AM-10:00 AM
Entry-Level Curriculum in Industrial Health
Joint program between Education Section and OHSIG

11:00 AM-12:30 PM
Occupational Health Hot Topics
Accessing Ergonomics Through the Internet
Mark Anderson, PT

Performing Arts SIG Programming
Moderator: Marshall Hagins, MA, PT

8:30 AM-10:00 AM
Introduction to Dance and Physical Therapy
Marika Molnar, MA, PT

10:00 AM-12:30 PM
Trouble-Shooting the Classical Dancers' Foot with Manual Solutions
Peter Marshall, MA, PT

1:30 PM-2:30 PM
Performing Arts: Dance Medicine Video

Joint Programming with Oncology Section

8:00 AM-10:00 AM
Limb Sparing

11:00 AM-12:00 PM
Basic Oncology for the Orthopaedic Physical Therapist

10:00 AM-11:00 AM & 2:30 PM-3:30 PM
Exhibit Hall Break

11:00 AM-12:00 PM
Foot and Ankle SIG Business Meeting

Foot and Ankle SIG Programming
Managed Care Considerations in the Foot and Ankle
Moderator: Tom McPoil, PhD, PT

12:30 PM-1:00 PM
Ligament Injuries to the Foot and Ankle
Joe Tomaro, MS, PT, ATC

1:00 PM-1:30 PM
Plantar Fisciitis, Plantar Heel Pain
Stephen Reischl, PT, OCS

1:30 PM-2:00 PM
Pronatory Foot Conditions
Joe Godges, PT, OCS

2:00 PM-2:30 PM
Panel Discussion

3:30 PM-4:30 PM
Foot and Ankle Biomechanical Abnormalities in Children with Disabilities and the Use of Posting in Orthoses
Dale Turner, MA, PT, PCS

4:30 PM-5:30 PM
Terminology Related to the Foot and Ankle
Joe Tomaro, MS, PT, ATC

11:00 AM-12:00 PM
Forum: Hand Therapy Certification
Joint Program with Hand Section

1:00 PM-2:30 PM and 3:30 PM-5:00 PM
Spine Dysfunction: Stability, Mobility, and Respiratory Mechanics.
Speakers: Mary Masserly, PT and Bob Johnson, PT, OCS
Joint Program with Cardiopulmonary Section

3:30 PM-5:00 PM
Management of the Stiff Hand
Speaker: S. Davila, PT
Joint Program with Hand Section

SATURDAY, FEBRUARY 15
8:00 AM-10:00 AM
Orthopaedic Section Business Meeting

10:00 AM-11:00 AM & 2:30 PM-3:30 PM
EXHIBIT HALL BREAK

11:00 AM-12:00 PM
Manual Therapy Roundtable Business Meeting
Manual Therapy Programming
Moderator: Laurie Kenny, PT, OCS

Manipulation: To Thrust or Not to Thrust

1:30 PM-2:30 PM
Chris Dollar, PT, MA, FAAOMPT

3:30 PM-5:30 PM
Richard Erhard, PT, DC

Performing Arts SIG Programming
Moderator: Marshall Hagins, MA, PT

11:00 AM-12:30 PM
Introduction to Music and Physical Therapy
Nicholas F. Quarrier, MHS, PT, OCS

1:30 PM-2:30 PM
Performing Arts Business Meeting

3:30 PM-5:30 PM
Lumbopelvic Asymmetry in Dancers
Katy Keller, MS, PT

11:00 AM-12:00 AM
Occupational Health SIG Business Meeting

1:30 PM-2:30 PM & 3:30 PM-5:30 PM
Research Platforms

Clinical Research Demonstrations Projects

1:00 PM-2:30 PM
Responsiveness of a Shoulder Outcome Scoring System
Brian Leggin, PT and Susan Brenneman, MS, PT

3:30 PM-5:00 PM
Intra and Interrater Reliability of Orthopaedic Data
Leslie Russek, PhD, PT
Joint Programming with Research Section

7:00 PM
Black Tie and Roses

SUNDAY, FEBRUARY 16
8:00 AM-12:00 PM
Current Concepts in Total Joint Replacement
Tentative Topic-Speakers TBA

8:00 AM-12:00 PM
Surgical and Rehabilitation Management of Children with Hip Dysplasias
Joint Program with Pediatrics

8:00 AM-12:00 PM
OHSIG Board Meeting

Meeting Minutes

Physical Therapy '96:
APTA Scientific Meeting & Exhibition
Minneapolis, MN - June 15, 1996

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

BOARD OF DIRECTOR REPORTS

A. President—Bill Boissonnault, MS, PT

1. Use of Robert's Rules of Order/Parliamentarian—Mr. Medard Kaiser-shot

2. =MOTION= Approve the agenda for the Physical Therapy 96: APTA Scientific Meeting and Exhibition Business Meeting as printed with the following amendments; add Bill Fromherz under the President's Report, add *JOSPT* Report under committee reports and add Open Forum after Unfinished/New Business. =PASSED=

3. =MOTION= Approve the minutes from the business meeting at CSM in Atlanta, GA on February 17, 1996 as printed in the Spring 1996 issue of *Orthopaedic Physical Therapy Practice.* =PASSED=

4. Meeting Format

5. Post Professional Residency Accreditation

I am very pleased to announce that the APTA Board of Directors voted to fund a clinical residency credentialling process. The funding period will begin in 1997. A proposed blueprint will be sent out for review. More information will be available later this year.

6. East River Professional Park

a. Sale/Leasing of property

i. The Section is negotiating with a group to buy one of the three lots available for sale on the Section property. This group is an assisted living residential facility. The Board will be reviewing their offer to purchase at this meeting.

ii. The Section office is located on the second floor of the new building. The first floor is lease space. We have been in contact with a number of businesses who want 1,000 square feet or less but we do not want to subdivide the first floor into more than two lease spaces. We are currently talking with a company out of Milwaukee, Wisconsin who is interested in about half the space.

b. Grand Opening—Fall 1996

7. Congratulations to new OCS's

8. Bill Fromherz passed away earlier this month. Bill was the secretary for the Section from 1983-87 and the member-at-large from 1987-89 and had a big part in the evolution of the Section. He will be dearly missed.

B. Vice President—Nancy White, MS, PT

1. The 1997 Paris Award winner is Rick Ritter. Rick will receive his award as well as present his acceptance address at the 1997 Combined Sections Meeting on Saturday evening prior to the Black Tie and Roses reception.

2. The Awards Committee will be working over the next few months to solicit nominations for the other Section awards; Excellence in Teaching Orthopaedic Physical Therapy, Outstanding Physical Therapy Student Award and the Outstanding Physical Therapist Assistance Student Award. Please send your submissions to the Section office or contact the Awards Committee.

C. Treasurer—Dorothy Santi, PT

The Section is approximately 17% over the expected budget in income through April, 1996 and 1.8% over the expected budget for expenses. The final payment on the Section office building will be made in the next couple of weeks. The reserve fund is over 60% of one year's operating expenses. The Section's reserve fund goal is to have 80% of one year's operating expenses in reserves. Total assets in 1987 were $255,000, now they are $1,859,000. Liabilities were $141,000 in 1987 and are now $281,000. The Section's equity went from $114,000 in 1987 to $1,578,000 in 1996.

D. Director—Michael Cibulka, MS, PT, OCS

1. The Section now has its own home page on the World Wide Web. Our address is http://www.orthopt.org. We have a link with our SIG home pages, Foot and Ankle and Occupational Health, as well as APTA's home page. The Section is also utilizing E-mail as much as possible. The Section office's E-mail address is orthostaff@centuryinter.net. We encourage everyone to communicate with the Section office through E-mail since it is by far the cheapest form of communication currently available. We don't want to discourage people from calling the office, however, if you need to talk to someone, please feel free to call.

2. Mike was appointed the Section's new bylaws reviewer at this meeting.

E. Director—Elaine Rosen, MS, PT, OCS

At the Combined Sections Meeting in Atlanta last February, Elaine was asked to chair a task force on chiropractic issues. Other members of the task force include Lola Rosenbaum, Steve McDavitt, Mari Bosworth and Scott Stephens. Information was gathered from the Media Spokesperson Network across the country in addition to what the task force was able to collect. We have also been working with AAOMPT in order to combine our efforts in accumulating this information. The material gathered to date includes all the physical therapy practice acts from all 50 states, all the chiropractic practice acts and their educational programs in all 50 states, attorney general opinions relating to chiropractors who are either advertising or billing for physical therapy services, attorney general opinions relating to physical therapists practicing manipulation and mobilization, chiropractic standards of practice, articles relating to efficacy of practice of mobilization and manipulation, etc. The Section office will be cataloguing and indexing this information and making the index available to anyone who needs it with all materials being housed at the Section office. We will be putting an advertisement in *Orthopaedic Physical Therapy Practice* and *PT Bulletin* letting people know the Section has this information available. An updated index will also be sent to all Chapter Presidents annually. All task force members were thanked for their work as well as all of the individuals who have sent information to the Section office.

F. Education—Lola Rosenbaum, PT, OCS

1. The application for the APTA Approved Provider is complete and will be sent to the APTA.

2. The Reference Guide is being updated and will be re-printed as a study guide for use in preparing for the OCS exam.

3. Programming for the 1997 Combined Sections Meeting in Dallas next February is being finalized. The preconference next year is entitled, Foot Orthoses: The Scientific Basis and Clinical Concepts sponsored by the Foot

and Ankle SIG.

4. A booklet of all speaker handouts will be put together for the 1997 CSM and sold, at cost, at the Section booth.

G. Research—Kelly Fitzgerald, PT

Application forms for the Clinical Research Grant Program have been finalized and the RFP's will go out July 1, 1996. Deadline for applications is December 1, 1996. Grant winners will be announced on or before March 1, 1997. Members of the Clinical Research Grant Program task force were thanked for their help in developing the program (Mary Milidonis, Paul Beattie, Kelly Fitzgerald and Dan Riddle).

COMMITTEE REPORTS

A. Membership—Terri Pericak, Executive Director

1. As of the end of April the total number of members in the Orthopaedic Section was 12,690.

2. The Section is receiving a second place award for the APTA Partners in Excellence in Conference Management.

B. *Orthopaedic Physical Therapy Practice*—Sharon Klinski, Managing Editor

Consideration is being given to publishing *OP* six times per year instead of quarterly as is currently being done in order to be more timely in conjunction with meetings. A survey can be found in this issue of *OP* to get feedback on this from the membership.

C. Orthopaedic Specialty Council—Joe Godges, MS, PT, OCS

1. The ABPTS and the Orthopaedic Section specialty council are co-sponsoring an exhibit at the American Academy of Family Physicians at their annual convention this year. The goal is to create a demand for specialist certification in physical therapy outside the physical therapy profession.

D. Practice—J. Scott Stephens, MS, PT, FFSBPT (See report under Section News.)

E. Public Relations—Mari Bosworth, PT (See report under Section News.)

F. Nominations—Carol Jo Tichenor, MA, PT (See report under Section News.)

G. Occupational Health SIG—Dennis Isernhagen, PT

1. The Occupational Health SIG now has a home page.

2. The Practice and Reimbursement Committee drafted a definition of Occupational Physical Therapy. A final copy is being reviewed by the Orthopaedic Section Board of Directors and if approved will be sent for final review by the APTA.

3. The document created by the IRAC committee (Guidelines for Work Hardening/Work Conditioning) is now in place. Other documents which are currently being worked on is The Document of Acute Physical Therapy Guidelines for Work Related Injuries. Two other areas which need definition and guidelines are functional capacity evaluation and prevention of work related injuries.

4. The Worker's Compensation Focus Group which is a tri-aliance between the Orthopaedic Section, APTA and the Private Practice Section, is looking at meeting October 26-27 in Washington D.C. This will be the third meeting of this group.

H. Foot and Ankle SIG—Tom McPoil, PhD, PT (See report under Section News.)

I. Performing Arts SIG—Brent Anderson, PT

1. The SIG has a meeting set up in Aspen, Colorado this summer which is also where the IADAMS International Association of Advanced Medicine conference will be held.

2. Current projects being undertaken are developing a vocabulary manual for performing arts as well as developing a reference list for performing arts companies throughout the country of specialists in performing arts physical therapy.

J. *JOSPT*—Pete Blanpied, Associate Editor/Debbie Durham, Managing Editor

1. Board of Associate Editors increased from two to eight in the past year.

2. Special Issues of *JOSPT*

a. The October 1996 issue will be on the topic of pain and headed up by Gary Smidt.

b. In 1997 the special issue will focus on the elite athlete and headed up by Kent Timm and Joe Threlkeld.

c. In 1998 there will be two special issues, one on articular cartilage and the patellofemoral joint by Kevin Wilk and nontraditional treatment approaches headed up by Pete Blanpied and Rick Clemente.

UNFINISHED/NEW BUSINESS

No new or unfinished business brought forth.

PRACTICE ISSUES FORUM

Meeting Adjourned by the President at 11:40 AM.

CALL FOR NOMINATIONS

FOR

THE 9TH ANNUAL ROSE EXCELLENCE IN RESEARCH AWARD

The Best Research Article of 1996

in

Orthopaedic Physical Therapy

The Research Committee of the Orthopaedic Section of the American Physical Therapy Association is soliciting nominations in order 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.

I. ELIGIBILITY FOR THE AWARD

The recipient must:

1) be a physical therapist licensed or eligible for licensure in the United States of America;
2) be a member of the American Physical Therapy Association;
3) be the primary (first) author of the published manuscript.

The article must be published in a reputable, refereed scientific journal between September 1, 1995 and August 31, 1996 to be considered for the award. Should the journal containing an otherwise eligible article experience a delay in releasing its August, 1996 issue, the article must be available to the general public no later than September 1, 1996 to be considered.

II. SELECTION CRITERIA

The article must have a significant impact (immediate or potential) upon the practice of orthopaedic physical therapy. The article must be a report of research but may deal with basic sciences, applied science, or clinical research. Reports of single clinical case studies or reviews of the literature will not be considered.

III. THE AWARD

The award will consist of a plaque and $500.00 to be presented at the Combined Sections Meeting in Dallas, TX, February 12–16, 1997.

IV. NOMINATIONS

Written nominations should include the complete title, names of authors, and the citation (title of journal, year, volume number, page numbers) of the research article. The name, address, and telephone number of the person nominating the research article should also be included.

Nominations (including self-nominations) will be accepted until close of business September 1, 1996 and should be mailed to:

Daniel L. Riddle, MS, PT
Research Committee Chair
Orthopaedic Section, APTA
c/o Department of Physical Therapy
Virginia Commonwealth University
McGuire Hall, 1112 East Clay Street, Room 209
Box 980224, MCV Station
Richmond, VA 23298-0224

Sponsor-A-Student Program

PURPOSE
To initiate students to the Orthopaedic Section, APTA, Inc., and serve as a liaison and/or assist in the transition for the student preparing to enter the profession of physical therapy.

THE SPONSOR SHALL:
- Assist with introducing the student to the Orthopaedic Section.
- Serve as a role model and a resource for questions.
- Sponsor the student financially by funding one year membership in the Orthopaedic Section.
- The cost for student membership is $15.00.

QUALIFICATIONS:
The sponsor must be a member of the Orthopaedic Section and interested in promoting the physical therapy profession.

PROCESS:
1. Sponsor will send in Sponsor Application to the Orthopaedic Section office.
2. Office will enter sponsor in computer and send sponsor's application to the PT or PTA programs within that sponsor's area (when possible), or to sponsor's school preference if indicated.
3. School liaison will coordinate with the student's interested in participating; assisting with matching the student with a sponsor.
4. School will forward students name to the Orthopaedic Section's office.
5. Orthopaedic Section will notify sponsor of his or her student.
6. Sponsor will contact assigned student.
7. An evaluation form will be sent to student participants and sponsors at the end of one year.

WHY GET INVOLVED?
To assist students in the transition from PT or PTA school to professional involvement in the APTA and the Orthopaedic Section.

FOR MORE INFORMATION ON THIS PROJECT, CONTACT THE ORTHOPAEDIC SECTION OFFICE AT 1-800-444-3982.

SPONSOR APPLICATION

NAME: _____ PT ____ PTA ____

Other degree(s) earned: _____

WORK ADDRESS: _____

_____

SCHOOL PREFERENCE (if any): _____

1. Would you be willing to sponsor a student(s) from a different school than the school that you listed? Y N
2. Would you be willing to sponsor a PTA student? Y N

AREAS OF EXPERTISE: (please state in 25 words or less)

_____

_____

_____

AREAS OF PROFESSIONAL INVOLVEMENT:

_____

_____

_____

AREAS OF PRACTICE:

____ Ortho ____ Pediatric ____ Geriatrics ____ Private Practice

____ Sports Medicine ____ Hand Rehab ____ Neuro ____ Home Health

____ SNF/ECF/ICF ____ Academic Institution ____ Research ____ Hospital

____ Rehab Ctr (Inpt.) ____ Rehab Ctr (Outpt.) ____ School system

____ Industry ____ Other _____

PLEASE RETURN TO:
ORTHOPAEDIC SECTION, APTA, INC.
2920 East Avenue South
La Crosse, WI 54601

Section News

VICE PRESIDENT'S REPORT

Awards Committee—The committee met via conference call to select the recipient of the Paris Award. The board approved the committee's recommendation, and the recipient has been notified. The recipient accepted the award which will be presented at CSM 1997. The committee members have submitted recommendations to the Board for nominations for APTA awards. The committee requests suggestions from the Board for other nominations. The committee will be happy to coordinate the nominations.

Other activities relate to responding to phone calls and correspondence regarding Orthopaedic Section business.

Nancy T. White, MS, PT
Vice President

BOARD OF DIRECTOR REPORT

I was charged to chair the Chiropractic task force. I have been in contact with all members of the task force and a memo was sent out to all media strike force representatives.

To present, we have received a fair amount of information including the following:

1. PT practice acts from all 50 states
2. information regarding chiropractic practice acts
3. attorney general opinions put together by APTA legal affairs
4. a very large packet of information regarding manipulation from Steve McDavitt & Mike Rogers

As per discussion with Bill, the plan is to have the Board review the collected information and then a decision can be made as to the best way to catalogue and store the information for future use as needed by members. A decision was made by Steve McDavitt and myself for the section to hold all the material gathered by AAOMPT allowing us to be the central clearing house rather than trying to gather information from multiple sources.

Elaine Rosen, PT
Board of Director

EDUCATION PROGRAM REPORT

Review Course

The Review Course is scheduled for:

July 13-17, 1996 in Cambridge, Massachusetts

November 2-6, 1996 in Orlando, Florida

Home Study Course

We are in the process of accepting registrations for the following course, 96-2 Topics in Orthopaedic Physical Therapy Assessment. The Orthopaedic Section will also be co-sponsoring a home study course with the Affiliate Assembly. The topic area will be arthritis and the course will also be available to Orthopaedic Section members.

Congratulations to Carolyn Wadsworth, MS, PT, OCS, CHT for being selected as our Home Study Course Editor. Thank you to all the candidates who applied for the position.

APTA Approved Providers

The application has been finalized and will be submitted to the APTA this month.

Study Guide Update

Our reference guide survey garnered some interesting comments and suggestions for PTs interested in taking the OCS exam. These comments will be added to the reference guide and the final product will be published as a study guide.

1997 Dallas CSM

Programming for Combined Sections is almost complete with our section SIGs planning some excellent presentations. Special thanks to Laurie Kenny, Marshall Hagins, Steve Reischl, Tom Watson and Gwen Parrott for their efforts. Please see the tentative schedule in this issue.

Lola Rosenbaum, PT, OCS
Education Program Chair

RESEARCH COMMITTEE

The annual Call for Participants for Research Platform and Poster Presentations and the Call for Nominations for the Rose Excellence in Research Award has been submitted to the *Journal of Orthopaedic and Sports Physical Therapy* and *Orthopaedic Practice*. These will appear in the *Journal* during the months of April through August. The Call for Papers will also appear in the Journal, *Physical Therapy* from May to August. The format for submission of abstracts has changed this year. We are participating with the rest of the Sections in a standardized call for abstracts. The only substantive change will be that the deadline for submission will be August 1 rather than September 1.

The bulk of the committee's work this year has been devoted to the development of the Orthopaedic Section Clinical Research Grant Program. We have developed an application and an RFP for submission. The External Grant Review Committee and the Clinical Research Grant Task Force is now reviewing the material. I want to thank the Research Committee and Mary Milidonis, Kelly Fitzgerald, and Paul Beattie for their help in developing the Program. I also want to thank Tara at the Section office for all her help in preparing the materials.

Daniel L. Riddle, MS, PT
Research Committee Report

ORTHOPAEDIC SPECIALTY COUNCIL REPORT

Council Composition: The Orthopaedic Specialty Council (OSC) is composed of three members who serve four year terms. Mary Ann Sweeney, MS, PT completes her OSC term in June, 1996. Jean Bryan, PhD, PT accepted an appointment for the vacated council position. The next council rotation will be in 1998.

Examination Information: There were 294 candidates who sat for the 1996 Orthopaedic Specialty Council Examination in March, 1996. Congratulations to the 210 candidates who successfully completed the examination. The following is a summary of Orthopaedic Certified Specialists by year group:
1989-26, 1990-35, 1991-45, 1992-179, 1993-140, 1994-160, 1995-167, 1996-210, TOTAL-862

Examination Construction: The OSC met the end of June at the ASI test center in Philadelphia to develop the 1997 orthopaedic examination. All

council members attended as well as invited cut score volunteers.

Item Development: There is a need for five new volunteers to become Orthopaedic Examination Item Writers. The deadline for application was July 15, 1996. Selected individuals will become members of the Specialization Academy of Content Experts (SACE) which is composed of both item writers and content experts. Selected item writers attend the item writing workshop which is held annually at the APTA Combined Sections Meeting. Each item writer is tasked to develop 12-16 exam items annually according to a schedule provided by the specialty council test development member, Joe Godges. Item writers receive consultation and assistance from the Content Experts (Alan Lee, Brenda Green and Ann Porter-Hoke).

Joe Godges and the Content Experts held an item development meeting. The members reviewed newly submitted items and developed additional items for the test bank.

Recertification Plan: The recertification plan received preliminary approval by the American Board of Physical Therapy Specialties. A survey of the recertification instrument will be sent to certified specialists during the summer. We are hoping for a good return on the survey and insightful comments from certified specialists on how to improve recertification portfolio and process.

1996 Examination Applications: Applications can now be downloaded electronically by accessing the APTA home page on the world wide web. The address is http://www.apta.org. Simply click on the Specialist Certification icon to access certification instructions and the application. The deadline was July 15, 1996.

Mary Ann Sweeney, MS, PT
Chair, Orthopaedic Specialty Council

PRACTICE COMMITTEE

The Practice Committee has received frequent inquiries concerning "critical pathways" and "protocols for care." Those inquiring have been cautioned to approach formal establishment of protocols or pathways with caution. These clinic-established standards may be used to define "standard of practice" in a legal proceeding. Deviations from a clinic approved protocol and the rationale for deviations should be documented. "Guidelines for Clinical Practice—Volume I" has been completed and is available from APTA. "Guidelines for Clinical Practice—Volume II" is currently being written and should be available during 1997.

There have been over fifty inquiries for additional information on the documentation software article written for the Summer, 1995 *OP.*

There were more than one hundred letters advocating support for clinical residency accreditation by APTA. Each of these letters received a response. APTA continues to explore residency accreditation.

The Orthopaedic Section has been represented by the Practice Committee at the PT-PAC and APTA Government Affairs functions.

Please contact me with orthopaedic practice related issues.

J. Scott Stephens, MS, PT
Practice Committee Chair

PUBLIC RELATIONS REPORT

The Resource Manual is currently being printed.

Plans are for both Terri Pericak, Executive Director of the Section and I to attend the 1996 National Student Conclave to be held in Birmingham, Alabama, October 18-20, 1996. The Section has contributed $3,000 to cosponsor the theme party/talent show at the Conclave.

The goal of the Sponsor-A-Student Program is to generate increased student membership while also educating the student about the benefits of belonging to both the APTA and the Orthopaedic Section.

Media Spokesperson Network (formerly "Media Strike Force"): The Orthopaedic Section now has commitments from 90 people located in 61 of the top 100 largest media markets in the United States. Efforts continue to obtain spokespersons for the remaining markets. Development of additional support materials to distribute to the entire media spokesperson network is ongoing.

Mari Bosworth, PT
Chair, Public Relations

NOMINATING COMMITTEE REPORT

The following slate was announced at CSM in Atlanta:

Treasurer: Dorothy Santi (unopposed)

Director: Robert Burles, Alan Lee, and Elaine Rosen (incumbent)

Nominating Committee: Kim Dunleavy, Nathaniel Grubbs, and Deborah Stetts

Ballots were mailed in mid-April. The following results were announced to the membership at the national meeting in Minneapolis:

Elected as Treasurer: Dorothy Santi
Elected as Director: Elaine Rosen
Elected as Nominating Committee Member: Kim Dunleavy

Total number of ballots sent: 11,143
Total number of ballots returned: 1,777
Total number of invalid ballots: 7
Total number of valid ballots: 1,770
Percentage of return: 16%

A change in the election calendar which was voted in 1995 has been initiated. A second election will be held in November, 1996 with the results announced at CSM in 1997. Nominees are currently being solicited for Director and Nominating Committee Member. Requests for nominees have gone out to all Executive Board members, special interest groups, and orthopaedic certified specialists and are due to the Nominating Committee by August 1st.

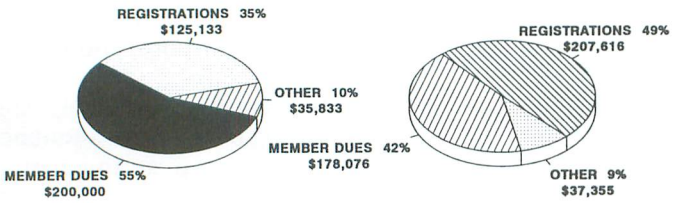
Carol Jo Tichenor (California) will step down as the chair of the Nominating Committee at the Scientific Meeting & Exposition, June, 1996. Tony Domenech will assume the Chair.

Carol Jo Tichenor, PT
Chair, Nominating Committee

FINANCIAL REPORT

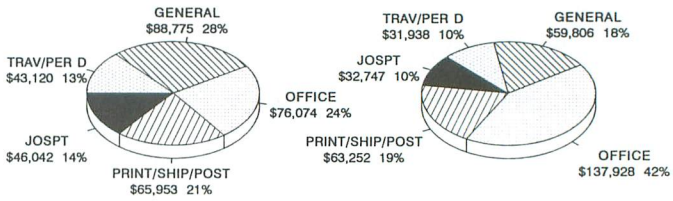
See graphs on the following page.

1996 BUDGET TO ACTUAL
INCOME: BREAKDOWN - April 30, 1996
(+17.2% over our expected budget)



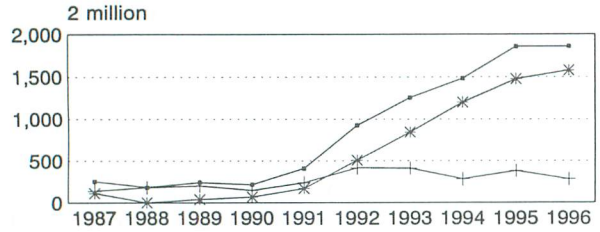
BUDGETED: $360,966.60 **ACTUAL: $423,046.58**

1996 YTD BUDGET TO ACTUAL
EXPENSE: BREAKDOWN - April 30, 1996
(+1.8% over our expected budget)



BUDGETED: $319,964.28 **ACTUAL: $325,671.16**

YEAR END FISCAL TRENDS
1987-1996 (1996 data is as of April 30, 1996)

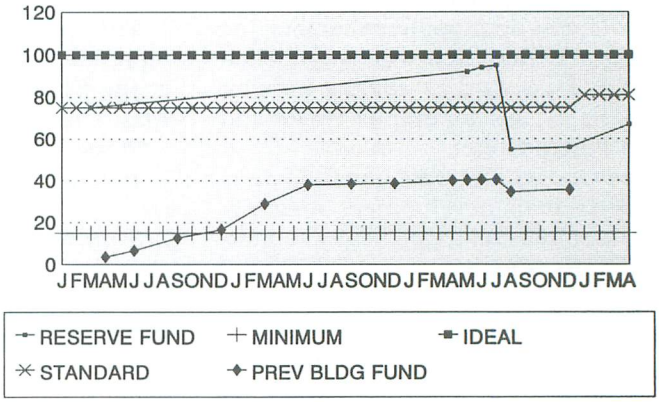


	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
ASSETS	255	185	243	217	410	925	1,257	1,484	1,858	1,859
LIABILITIES	141	183	203	148	240	417	413	283	382	281
EQUITY	114	2	40	69	170	508	844	1,201	1,477	1,578

ASSETS LIABILITIES EQUITY

To nearest thousand

RESERVE FUND
January 1, 1993 to April 30, 1996



ORTHOPAEDIC
PHYSICAL THERAPY

TOPICS IN ORTHOPAEDIC PHYSICAL THERAPY ASSESSMENT

HOME
STUDY
COURSE 96-2

Course Length: 6 Sessions

July-December 1996

Proposed Authors and Topics

Jill Binkley, MS, PT
Measurement concepts in orthopaedic physical therapy assessment

Terry Randall, MS, PT
Medical screening and differential diagnosis

Paul Howard, PhD, PT
Manual examination of neural tissues

Thomas Zastowny, PhD
Psychological screening for patients with orthopaedic disorders

Diane Jette, PT
Outcome assessment: general principles

Anthony Delitto, PhD, PT
Outcome assessment: spine

The Editor

Jonathan M. Cooperman, MS, PT, JD
Rehabilitation & Health Center, Inc.
3975 Embassy Parkway
Akron, OH 44333
(216) 668-4080 Fax (216) 665-1830

Objective

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

Registration Fees

Register by June 7, 1996.
Limited supply available after this date.

$150 Orthopaedic Section Members
$225 APTA Members
$300 Non-APTA Members

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

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

Educational Credit

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

Questions

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

Registration Form

Name _____

Mailing Address _____

City/State/Zip _____

Daytime Phone _____ APTA # _____

For clarity, please enclose business card.

Please make check payable to: Orthopaedic Section, APTA.

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

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

Please add Wisconsin, Stadium, and County tax where applicable. County _____.

Mail check and registration to: Orthopaedic Section, APTA, 2920 East Avenue South, La Crosse, WI 54601 or Fax registration & Visa or MasterCard number to 608-788-3965

Visa/MC (circle one) # _____ Expiration Date _____

Signature _____

AWARD FOR EXCELLENCE IN TEACHING OF ORTHOPAEDIC PHYSICAL THERAPY

PURPOSE

To recognize and support excellence in instructing OPT principles and techniques through the acknowledgment of an individual with exemplary teaching skills.

ELIGIBILITY

1. The nominee must be a member in good standing of the Orthopaedic Section of the APTA. The nominee must have taught or presently be teaching either physical therapy or physical therapy assistant students the principles and clinical applications of Orthopaedic Physical Therapy for five years or more.
2. The nominee may be either a faculty member (full-time or adjunct) or a clinical instructor of an accredited physical therapy or physical therapy assistant program.
3. Members of the Section Awards Committee are excluded from eligibility during their term of office.

CRITERIA FOR SELECTION

The Awards Committee will consider the following as guidelines in the selection process:

1. The instructor devotes the majority of his professional career to student education.
2. The instructor teaches from a sound, comprehensive, and current knowledge base, integrating basic science with the principles of orthopaedic physical therapy.
3. The instructor demonstrates excellence in instructional methods, presentation techniques, planning and organizational skills, and the ability to motivate students.
4. The instructor serves as a mentor and role model with evidence of strong student rapport.
5. Teaching materials are innovative and well-designed.
6. Instructional techniques are intellectually challenging and promote retention or necessary knowledge and skills.
7. The instructor demonstrates an ability to relate academic knowledge to clinical practice.
8. The instructor displays objectivity in the evaluation and presentation of ideas, hypotheses, and concepts.
9. The instructor is receptive to student and peer feedback.

PROCEDURE FOR NOMINATION

1. Any member of the Orthopaedic Section may nominate candidates for the award.
2. One original typewritten set and four duplicates of all materials submitted for each nomination must be received by the Administrative Director at Section office by December 1 for consideration for the award in the following year.
3. The materials to be completed and submitted for each nomination shall include the following:
   a. A support statement from the nominator, highlighting reasons for the nomination and clarifying the relationship between the nominator and nominee.
   b. A support statement from at least one faculty member from all physical therapy or physical therapy assistant educational programs with which the nominee is affiliated.
   c. Support statements from at least two professional colleagues.
   d. Support statements from at least two current and/or former students. If the nominee is a clinical instructor, the clinical education experience must be full-time for a minimum of six weeks.
   e. The nominee's curriculum vitae.
4. The nomination materials should document examples of how the nominee fulfills the criteria for this award.

PROCEDURES FOR REVIEW AND SELECTION

1. Nomination materials shall be submitted to the Section office. The Section office will retain the original set of materials and will provide the Awards Committee with copies for review.
2. The Awards Committee will review the nominations and recommend a recipient to the Executive Committee.
3. Any members of the Awards Committee who are closely associated with the nominee will abstain from participating in the review and selection process.
4. The award will be presented only if there are qualified candidates, and one is selected.
5. Nomination materials are considered the property of the Awards Committee, who will maintain their confidentiality.
6. Nomination materials will not be returned. If any individual is not selected for the award in a given year, that individual may be nominated in a subsequent year. New nomination materials must be submitted in subsequent years.

NOTIFICATION OF AWARD

1. The recipient of the award will be notified by the Section president.
2. Those nominees not selected will be so informed in writing.
3. The nominators of individuals not selected will receive a letter thanking them for their participation and informing them of the award recipient.
4. The confidentiality of the Excellence in OPT Teaching Award will be maintained until the recipient has been notified.

THE AWARD AND ITS PRESENTATION

1. The Orthopaedic Section will reimburse the round trip coach airfare from any site in the United States or Canada to the APTA Annual Conference Meeting site, two day per diem, consistent with the Section's current reimbursement rates and one day's conference registration.
2. The award will consist of an appropriate plaque and a $250.00 honorarium.
3. The award will be presented at the APTA Annual Meeting (CSM) by the Chair of the Awards Committee.

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, 1996. 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 years)
Takes on responsibilites and duties and acts as liaison to various committees as designated by the President.

☐ NOMINATING COMMITTEE MEMBER (3 years):
Should have broad exposure to membership to assist in formation of the slate of officers.

Nominator: _____

Address: _____

_____

Phone: _____

PLEASE RETURN BY SEPTEMBER 1, 1996 TO:
Tara Fredrickson,
Orthopaedic Section, APTA
2920 East Avenue South
La Crosse, WI 54601

OUTSTANDING PT/PTA STUDENT AWARD

PURPOSE

1. To identify a student physical therapist (first professional degree) with exceptional scholastic ability and potential for contribution to orthopaedic physical therapy.
2. To provide the means for an exceptional student to attend and participate in a national meeting, with the intention that this exposure will encourage future involvement in Orthopaedic Section activities.

ELIGIBILITY

1. The nominee must be currently enrolled in a PT or PTA program.
2. The nominee must be a member of the Orthopaedic Section, APTA, Inc.

CRITERIA FOR SELECTION

1. The student shall excel in academic performance in both the professional and prerequisite phases of their educational program.
2. The student shall demonstrate exceptional nonacademic achievements, representing initiative, leadership, and creativity.
3. The student shall be involved in professional organizations and activities that provide the potential growth and contributions to the profession and orthopaedic physical therapy.

PROCEDURE FOR NOMINATION

1. Any member of the Orthopaedic Section may nominate candidates for this award.
2. One original set and four duplicates of all materials submitted for each nomination must be received by the Executive Director at the Section office by November 1, for consideration for the award in the following year.
3. The materials submitted for each nomination shall include the following:
   a. A support statement from the nominator, highlighting reasons for the nomination and clarifying the relationship between the nominator and nominee.
   b. A support statement from two faculty members in the educational program in which the nominee is enrolled.
   c. Support statements from one faculty member outside of the PT or PTA department.
   d. Support statements from at least two student colleagues.
   e. A resume and cover letter from the nominee detailing previous health care experiences, honors and awards, evidence of service activities, and participation in professional activities.
4. The nomination materials should document examples of how the nominee fulfills the criteria for this award.

PROCEDURE FOR REVIEW AND SELECTION

1. Nomination materials shall be submitted to the Section office. The Section office will retain the original set of materials and will provide the Awards Committee with copies for their review.
2. The Awards Committee will review the nominations and recommend the most qualified candidate to the Executive Committee.
3. The award will be presented only if there are qualified candidates, and one is selected.
4. Nomination materials are considered the property of the Awards Committee, who will maintain their confidentiality.
5. Nomination materials will be not be returned. If any individual is not selected for the award in a given year, that individual may be nominated in a subsequent year. New nomination materials must be submitted in subsequent years.

NOTIFICATION OF AWARD

1. The Section President will notify the recipient by December 1st and obtain written confirmation of acceptance by December 15.
2. The nominators of individuals not selected will receive a letter thanking them for their participation and informing them of the award recipient.
3. The confidentiality of the Outstanding Student Award will be maintained until the recipient has been notified.

THE AWARD AND ITS PRESENTATION

1. The Orthopaedic Section will reimburse the recipient for round trip coach airfare from any site in the United States or Canada to the APTA Combined Sections Meeting, four days per diem, and conference registration.
2. The student will receive a certificate suitable for mounting.

Occupational Health Physical Therapists
Special Interest Group
Orthopaedic Section, APTA, Inc.

Newsletter

SUMMER 1996 VOLUME 3, NUMBER 3

THE IMPACT OF TRANSITIONAL WORK OPPORTUNITIES IN THE MANAGEMENT OF INJURED WORKERS

Early return-to-work (RTW) programs are becoming accepted in industry as a necessary component of corporate disability cost containment programs. Recent studies have identified structured transitional work as one important reason for reduction in worker's compensation (WC) and disability costs when comparing similar sized industries doing business within the same state WC system. Early RTW programs are gaining popularity as a management tool to combat the financial burdens of worker's compensation insurance. Recent insurance industry statistics suggest that injured employees involved in structured, goal-oriented transitional work programs return to the job in approximately 50% of the time as compared to those who, under similar circumstances, were not provided with this opportunity. The net result is that both medical and indemnity costs may be reduced by as much as two thirds with a reduction of 50-60% in total case costs.

Transitional work is any job duties or combination of tasks that may be performed safely by the returning employee whose physical abilities to perform all essential physical job functions, at a full-time work schedule, has been compromised by illness or injury. Two assumptions must be made regarding safe return of the injured worker to the workplace:

1. Individuals recover and increase safe function incrementally and at varying rates.
2. Most work tasks and/or schedules can be modified for short time periods without creating "no work tasks" or reducing overall productivity.

Transitional work needs to be time limited wherein the functional demands and work tolerance levels can be progressed while performing productive work for wages. In a union environment, a joint labor-management effort is essential to draft policies and procedures for transitional work programming.

Placing a returning employee in a transitional work program is driven by medical recommendation and reasonable expectation that the employee has the physical and emotional capacity to regain all or most of the physical ability required to safely return to full duty employment. Transitional work programs should implement work return strategies that are effective in placing workers in their pre-injury work departments doing as much and as many of their original work tasks as possible. The returning worker should be closely monitored and progression of transitional work duties facilitated on a timeline schedule clearly outlined to all parties prior to return to the work-site. This rather innovative approach is designed to keep workers at work and close to their regular job and work environment. This will maximize steady progression through the work return program and greatly enhance the chance for return to full, unrestricted competitive employment.

Employers should involve consultative and clinical work-site rehabilitation services to provide monitored programming that involves real work tasks at the work station, allowing workers with limitations to incrementally resume his or her duties under the supervision of a licensed therapist with adequate knowledge and training in occupational health. Parameters to be addressed are:

1. Rehabilitation to return to optimal, safe physical function through an individualized transitional work plan,
2. Identification and elimination of ergonomic risk factors,
3. Modification of the administrative environment to promote transitional work,
4. Labor relations to promote a sense of collaboration and accommodation, and
5. Data collection and interpretation to identify potential permanent changes.

The successful development and implementation of an individualized transitional work plan requires:

1. Accurate job analysis with emphasis on essential physical work functions,
2. Quantified functional capacity data,
3. Goals for rehabilitation during the transitional work timeframe, and
4. Clear identification of plan details such as program length, realistic return to work goals, specific work task progression, and amount/intensity of therapeutic supervision estimated to achieve goals and/or make program modifications if necessary.

(Continued on page 30)

CONTENTS

Work-site rehabilitation intervention provides the rehabilitation team and employer with direct input on variable factors such as labor relations, supervisory attitudes, co-worker relationships, and physical tolerance levels. Although there are many benefits, the transitional return to work effort maintains regular work attendance, increases employer participation in the work return process, allows the injured worker to resume regular contact with co-workers and supervisors, ensures productive work while promoting positive work behaviors, and minimizes lost time with associated direct and indirect costs.

An effective transitional work return program requires data collection and interpretation to evaluate success, determine change, and identify potential problems to be addressed. The following criterion may be used as outcome indicators:

1. Cost effectiveness through reduction in medical, indemnity, and indirect costs,
2. Reduction of lost time days,
3. Worker satisfaction,
4. Supervisor and union satisfaction,
5. Number of employees successfully returning to full duty work,
6. Length of successful return,
7. Recidivism rate relative to same vs different diagnosis, and
8. Number of workers requiring permanent job accommodations.

Transitional return to work programs provide employers with an organized system for expediting safe and timely return to work for employees with physical disabilities. The impact of rising medical and indemnity costs which reduce profits and ADA, employers are now demonstrating openness and a willingness to explore creative solutions in disability management. Through development of transitional work programming, employers are finding that they can significantly reduce the intangibles and variability that often surround injured employees' recovery and ultimate success and longevity in safe return to productive employment. Transitional work programs result in markedly lower overall costs for the employer and protect the employability of the worker. These programs are effective in preventing many instances of chronic occupational injury that can rapidly develop during a period of separation from the work environment.

Excerpted from R.E. Breslin and J.A. Olsheski, *The Impact of a Transitional Work Return Program on List Time*, NARPPS Journal, Volume 11, Number 2, Spring, 1996.

POSITIVE ATTITUDE AND KNOWLEDGE ARE KEY ELEMENTS TO QUICK RECOVERY FROM WORK INJURY AND ILLNESS

Thinking about impairment or refusal to feel victimized may have a greater impact on postinjury or illness return to work than factors such as getting along with the boss, according to a new Gallup study in collaboration with Fortis Benefits Insurance Co. In this innovative study, researchers conducted focus groups, interviewing 275 Fortis disability claimants to explore personal ethics and values of workers coping with an illness or injury that resulted in time off work.

The following is a synopsis of study results:

- 70% of persons who return to work quickly postinjury or illness never think about impairment; 34% of persons who return relatively slowly almost never think about their impairment.
- 76% of those returning quickly refuse to feel victimized by the condition that took them off of the job; 43% of those returning slowly refuse to feel this way.
- 90% of those returning to work in a timely manner reported a positive relationship with their employer (boss) as compared with 83% of those whose return rate was slower.
- Individuals who return to work soon post-injury or illness onset are more likely to report a strong overall work ethic.
- Those who return to work quickly are more likely to participate fully in the rehabilitation effort and become actively involved with treatment decisions.
- Those who rapidly reintegrated most effectively into the work environment tend to be more innately resilient, proactive, conscientious, and demonstrate more than average willpower.

Stevens OSHA Reporter OSHA WEEK, January 8, 1996, Volume 7, Number 2

LEGAL BEAGLE

By Kathy Lewis, JD, MAPT

How does the ADA affect physical therapy employers?

Physical therapy managers are not immune from ADA claims. When assessing performance of students, physical therapists or support personnel, you may encounter a learning disability claim. When the department manager decides to dismiss an employee because of poor performance history, the manager should assess whether poor performance is related to a qualified disability and be willing to provide reasonable accommodations. In contrast, managers are not expected to tolerate poor performance if they can show compliance with the ADA or that the employee does not have a qualified disability. Employees do not have an absolute right to refuse reasonable accommodations.

The following recent cases from health care settings represent the above points. Primary questions found in these cases are:

1. *Is there a disability?*
2. *Does the individual meet essential job functions to meet the test for a "qualified individual with a disability?"*
3. *If essential job functions can not be met, can the employer provide reasonable accommodations to allow meeting this test?*
4. *If reasonable accommodations are available, did the individual refuse to accept those accommodation(s), thus, waiving employee protective rights under the ADA?*

After poor performance during the first year of medical school, a student claimed that he was dyslexic. He was allowed to participate in a decelerated program during the subsequent 2 years, but was dismissed during his fourth year. Although the parties agreed that the student was dyslexic, the court concluded that the student's poor performance was based on his inability to process information promptly and accurately. (A clinical psychologist concluded that the student's IQ was 78). The school could not be expected to fundamentally alter the nature of its program nor give him extra time for clinical decisions while practicing in the clinic. According to this case, you do not need to make accommondations that fundamentally alter the practice of physical therapy.

In another recent case, a radiology aide who was suffering from sickle cell anemia had missed eighty-two days of

work and was often late. After progressive disciplinary actions and counseling, the hospital terminated the aide's employment. Subsequently, the aide filed a claim alleging violation of his rights under the ADA (termination because of his disability and failure to make reasonable accommodations.) The court ruled that even though the aide had a disability (sickle cell anemia), he was not otherwise qualified because he could NOT meet essential job function (regular and stable attendance). Since he was unable to perform his job while absent and was not willing to transfer to another department, his rights under the ADA had not been violated. Johnson v. Children's Hosp. of Philadelphia, No. 95-1554 (3d Cir. Feb. 23, 1996)

A nurse with eleven years experience was working in a cardiac catheterization lab. During the latter part of her employment, she sustained cervical injuries from a car accident. After her return to work, she was wearing a lead apron for an extended period of time, then experienced motor function impairment in her right hand. After this five-and-a-half hour procedure, she was unable to perform a task as requested by her supervisor. She was offered other nursing positions in the hospital but refused them because none were day positions. After her termination, she filed suit against the hospital alleging that her ADA rights had been violated. The court concluded that she was not disabled because she could perform other nursing duties and she was not perceived as disabled because the hospital offered her other positions. The court stated that not being able to work in a position of one's choice does not constitute a disability. Mowat-Chesney v. Children's Hosp., No. 94-D- 1552 (D. Colo. Mar. 5, 1996)

An Administrative Review Board permanently restricted a psychiatrist from direct patient contact and direct patient care. The Board's decision was based on findings that he had epilepsy and an emotional disorder which affected his ability to safely and competently practice medicine. The record included complaints from twelve patients with instances of inappropriate behavior. The appellate court confirmed ARB's decision and denied the psychiatrist's ADA claim. He was unable to perform the job functions without accommodations. The accommodations suggested by medical specialists were found to be unreasonable, placing undue burden on co-workers and supervisors. In re Moran v. Chassin, No. 72598 (N.Y. App Div., 3d Jud. Dept Mar. 7, 1996)

In the above cases, the courts concluded that the medical student with dyslexia, the radiology aide with sickle cell anemia, and the psychiatrist with epilepsy and an emotional disorder had disabilities. However, the nurse who experienced motor impairment after wearing a lead apron for long periods of time did not have an actual nor a perceived disability.

According to the decisions of these cases, managers do not need to make accommodations that fundamentally change the practice of physical therapy nor place an undue burden on others to assure a safe work environment. When alternate positions are available to meet reasonable accommodations, the employee can not refuse to accept the accommodation and simultaneously claim that ADA rights have been violated.

ADA case law will continue to evolve for an unpredictable time frame. Jurisdictions other than those represented in the above cases may reach similar conclusions through different rationale or conclusions may differ. One consistent trend of the courts seems to be decisions that protect safety of others. Arguably, the United States Supreme Court's recent refusal to review a decision by the Fifth Circuit court supports the importance of safety. In this case, an insulin dependent diabetic bus driver was found not to be a "qualified individual with a disability" because the significant risk to the health and safety of others could not be eliminated by reasonable accommodation. Daugherty v. El Paso, Tex., No. 95-1083, cert. Denied, 64 U.S.L.W. 3623 (U.S. Mar. 18, 1996)

SECRETARY'S CORNER

The occupational health physical therapist special interest group has worked very diligently to draft a definition of occupational health physical therapy. This is a great step toward being able to quantify our practice specialty and develop clinical competencies on which to base our clinical effectiveness. The OHPTSIG Practice and Research Committees should be commended for it's efforts in writing the draft definition, distributing it to the membership and Executive Board for field review, and preparing the final draft for presentation to the Orthopaedic Section Executive Board.

The completion of the occupational health physical therapy definition project is only one of many accomplishments of the OHPTSIG year to date. Occupational rehabilitation and industrial consultation by physical therapists has become a rapidly growing subspecialty. Our special interest group continues to be proactive in its mission to develop a strong presence for physical therapists in the industrial arena. If we are to continue to progress toward the ultimate goal of becoming accepted as occupational health physical therapy professionals in the industrial marketplace, we need membership assistance through participation. There are many ways to participate more actively in our OHPTSIG. You may volunteer for committee membership, write and submit newsletter articles, attend annual meetings at CSM, and /or contact the President with other ideas and suggestions to input into existing projects or to recommend areas or concerns you wish the SIG to address.

To volunteer for OHPTSIG participation, contact:

Dennis Isernhagen, President
(212) 722-1399 or
DDIIWIN@AOL.COM

Submitted for the Summer edition of the OHPTSIG newsletter by Bobbie Kayser, PT Secretary Occupational Health Physical Therapist Special Interest Group

CALL FOR NOMINATIONS

The Nominating Committee of the Orthopaedic Section's Occupational Health Physical Therapists SIG is soliciting candidates for the offices of President, Treasurer and Member of the Nominating Committee. The election will be held via mail ballot. Watch for your ballot in December!

If you wish to be more involved and contribute to the growth and development of the Occupational Health Physical Therapy, please contact the Chair of the Nominating Committee or Tara Fredrickson at the Orthopaedic Section office, 1-800-444-3982.

NEWS BRIEFS:

WORKERS' COMPENSATION REFORM ON THE WAY?

The nation's workers' compensation (WC) system requires considerable change, according to a survey of state insurance commissioners and legislators conducted by AIG Managed Care, Inc. In fact, 63% of those surveyed say the WC system needs a "fundamental change" or "complete overhaul." Only 29% say the system "works pretty well." In all, 25 state insurance commissioners and 175 state legislators were contacted for their opinions. The majority, or 84%, did not anticipate uniform WC standards within five years. The respondents cited the following legislative reforms as priorities:

1. 44% Prevent fraudulent claims
2. 40% Change the definition of compensable injury/illness
3. 39% Reinstate requirements for reasonable accommodation for injured employees

Of reforms expected to be enacted within three years, respondents cited the following:

1. 63% Use of managed care organizations
2. 62% Establish a competitive state WC fund
3. 60% Tighten limits on the length of temporary benefits
4. 59% Restrict benefit packages

For detailed survey information, contact Lois Levey, AIG Managed Care, Inc., 70 Pine Street, New York, NY 10270; (212)770-7447.

Excerpted from Professional Safety, page 21, January, 1996.

STUDY TO RESEARCH PHYSICIANS' DECISIONS ON BACK INJURY RETURN TO WORK RELEASE

The California Department of Industrial Relations Division of Workers' Compensation has embarked on a new study to determine how physicians judge when to release employees with disabling low back injuries back to work. This study is funded by a research grant from the National Institute of Occupational Health and Safety (NIOSH). The information gained should facilitate improved management of the injured worker in the return to work effort which continues to be a critical element gained should facilitate improved management of the injured worker in the return to work effort which continues to be a critical element in state workers' compensation systems. This study will also provide new insight into the injured worker's experience in returning to the work environment following a disabling back injury. Although physicians play a key role in the return to work process, little is known about rationale for return recommendations. The study will involve a sample of 300 physicians from varying health care delivery systems.

For additional information about this study, contact Richard Stephens (415)975-0721 or Rick Rice, DIR, (714)935-2812.

Stevens' OSHA Reporter OSHA WEEK, February 19, 1996, Volume 7, Number 8.

Membership in the Occupational Health SIG is open to any member of the Orthopaedic Section. To join, simply contact Tara Fredrickson at the Section office, 1-800-444-3982.

President:
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ph: 218/722-1399
FAX: 218/722-1395
E-mail: DDIIWIN@AOL.COM

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Practice & Reimbursement Committee Chair:
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Nominating Committee Chair:
Helene Fearon, PT
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FAX: 602/997-8020

Advisory Group on Ergonomics:
Mark Anderson, PT
ph: 612/368-9214
FAX: 612/368-9249
E-mail: 76524.1134@compuserve.com

MORE COMPANIES, AGENCIES SEEK CONSULTANTS FOR HEALTH, SAFETY COMPLIANCE

With the changes in government and downsizing of programs, agencies and industries are recognizing how important safety is as a part of the overall work operation. Businesses using specialized safety consultants (such as occupational health physical therapists, ergonomists, etc.) have increased 150 percent in the past seven years - from 8 percent in 1988 to 20 percent today according to American Industrial Hygiene Association data. The move toward outside safety and health contractors appears to be getting support from the highest levels of government. Vice President Al Gore has encouraged federal agencies to work more closely with consultants to accomplish mutual goals. This presents an excellent opportunity for qualified physical therapist consultants in industry.

Stevens OSHA Reporter, OSHA WEEK, May 1995

Foot and Ankle Special Interest Group

Orthopaedic Section, APTA, Inc.

CHAIR'S REPORT

The FASIG held its 2nd annual business and educational meeting at the Combined Sections Meeting in Atlanta. First of all I want to thank Steve Baitch, Catherine Patla, and Beth Fisher, for providing the membership with a series of excellent lectures and discussion sessions during the education portion of the FASIG program in Atlanta. The interest generated by these three speakers was obvious, since there was stand-ing room only for each of the three topics covered by the speakers. Again, thanks to these three individuals for taking the time to share their expertise to the FASIG membership.

The minutes of the business meeting submitted by Secretary/Treasurer Mark Cornwall, follow my report. I would like to just highlight several aspects of the business meeting for you. One of the items on the business meeting agenda was the election of a Vice-Chair as well as two Nominating Committee members. Prior to announcing the results of the election, I would first like to acknowledge the outstanding contributions made by outgoing FASIG Vice Chair, Steve Reischl as well as Nominating Committee members Jim Birke and Michael Mueller. All of these individuals have worked extremely hard to help get the FASIG up and running for the past three years. The Nominating Committee, with Irene McClay as chair, did an excellent job in putting together an excellent slate of candidates. Thanks to all those Orthopaedic Section members who volunteered to run for office. The results of the election were, Steve Reischl, Vice-Chair and Michael Mueller and Debbie Nawoczenski, Nominating Committee. At our next business meeting at CSM in Dallas, the FASIG will be electing a Chair, Secretary/Treasurer, as well as two Nominating Committee members. If you are interested in running for these positions, please contact Irene McClay (302-831-8910) or Michael Mueller (314-286-1400) by December 15, 1996.

During the business meeting, Joe Tomaro, Chair of the Practice Committee, reported on the proposed foot and ankle terminology which had been developed by the American Orthopaedic Foot and Ankle Society. Joe and his committee definitely felt that the FASIG should work to develop a physical therapy based foot and ankle terminology. I charged the Practice Committee, with approval of those members in attendance, to develop a physical therapy foot and ankle terminology which we could then submit to the Section for possible adoption. Joe will be reporting on the progress with the development of the foot and ankle terminology in Dallas.

Irene McClay, Chair of the Research Committee, reported on the results of the survey which was included in last year's issue of *Orthopaedic Practice*. Irene reported that her committee is attempting to find possible funding sources for FASIG members wanting to participate in foot and ankle research internships.

Mark Cornwall, FASIG Secretary/Treasurer, has been busy developing a FASIG World Wide Web home page. In addition, Mark has also created a FOOT-L moderated List server which would allow clinicians to discuss clinical and research questions via e-mail or Internet. Instructions on how to enroll in the FOOT-L as well as how to find the FASIG home page are provided by Mark below.

As you can see, the FASIG is alive and well thanks to the hard work of all its members. I want to invite you to join and participate in the activities planned by the FASIG at CSM in Dallas. Vice Chair Steve Reischl and the Program Committee have planned an excellent educational program as well as an exciting Pre-Conference Course of Foot Orthoses. These two programs will no doubt prove to be stimulating and informative for all of those able to attend.

Finally this year, members of the FASIG will be submitting a series of clinical articles related to the foot and ankle for publication in *Orthopaedic Practice*. Steve Baitch starts off this years series with a article on foot orthoses entitled "The Blake Inverted Orthotic: An Overview." Steve has extensive experience in the prescription and fabrication of foot orthoses, and I thank him for taking the time to share his expertise using the inverted orthotic technique with us in this issue.

If you have any questions or suggestions regarding the FASIG, please do not hesitate to contact me by either phone (520-523-1499), FAX (520-523-9289), or e-mail (Tom. McPoil@nau.edu). I look forward to seeing you in DALLAS!

Tom McPoil
Chair, FASIG

VICE CHAIR and PROGRAMMING COMMITTEE REPORT

Vice Chair Steve Reischl and the Programming Committee have developed two excellent educational programs to take place at the upcoming CSM to be held in Dallas. In addition, to the regular educational meeting, which follows the FASIG business meeting, this year the FASIG will be sponsoring a pre-conference course entitled "Foot Orthoses: The Rationale for Clinical Use." The tentative outline for both of these programs is listed below and we hope to see you at both sessions in Dallas!

FASIG PROGRAM at CSM, DALLAS

The business meeting and educational session is scheduled for Friday at the 1997 CSM in Dallas. The tentative FASIG program is as follows:

10:30 to 11:30
FASIG Business Meeting

12:30 to 2:30
Managed Care Considerations in the Treatment of Foot Problems

12:30 to 1:00
Ligament Injuries to the Foot and Ankle
Joe Tomaro, MS, PT, ATC

1:00 to 1:30
Plantar Fasciitis and Heel Pain
Steve Reischl, PT, OCS

1:30 to 2:00
Pronatory Foot Conditions
Joe Godges, PT, OCS

2:00 to 2:30
Panel Discussion

2:30 to 3:30
EXHIBIT BREAK

3:30 to 4:30
Foot and Ankle Biomechanical Abnormalities in Children with Disabilities and the use of Posting in Orthoses
Dale Turner, MA, PT, PCS

4:30 to 5:30
Terminology Related to the Foot and Ankle
Joe Tomaro, Chair, FASIG Practice Committee

PRE-CONFERENCE COURSE—CSM DALLAS

FOOT ORTHOSES:
THE SCIENTIFIC BASIS & CLINICAL CONEPTS

(Tentative Program)

MORNING SESSION—The Scientific Basis for the Use of Foot Orthoses

8:00 to 8:15
Introduction

8:15 to 9:15
The Basis for the Use of Foot Orthoses: *Functional Foot Mechanics*
Thomas McPoil, PhD, PT, ATC

9:15 to 10:15
The Premise for Abnormal Foot Function: *The Typical Pattern of Foot Movement During Walking*
Mark W. Cornwall, PhD, PT, CPed

10:15 to 10:30
BREAK

10:30 to 11:30
The Essential Elements of Foot Orthoses Design: *Pathomechanics Affecting Foot Movement*
Robert Donatelli, PhD, PT, OCS

11:30 to 12:30
Determining the Optimal Foot Orthoses Prescription: *The Foot and Ankle Examination*
Michael Wooden, MS, PT, OCS

12:30 to 1:30
LUNCH (on your own)

AFTERNOON SESSION—The Design and Prescription of Foot Orthoses: Three Clinicians' Viewpoints

1:30 to 2:30
First Clinician: Robert Donatelli, PhD, PT, OCS

2:30 to 3:30
Second Clinician: Michael Wooden, MS, PT, OCS

3:30 to 3:45
BREAK

3:45 to 4:45
Third Clinician: Thomas McPoil, PhD, PT, ATC

4:45 to 5:45
Panel Discussion with Questions from the Audience

5:45 to 6:00
Summary and Adjourn

Minutes of the Foot and Ankle Special Interest Group (FASIG) Meeting
February 17, 1996
Combined Sections Meeting of the APTA,
Atlanta, Georgia

The meeting was called to order by Tom McPoil at 12:31 pm. There were 22 individuals in attendance.

Motion:
It was moved by Michael Mueller and seconded by Steve Baitch to approve the minutes of the February 11, 1995 meeting in Reno, NV. Passed by unanimous vote.

Officer/Committee Reports:
Chair:
Tom McPoil reported on Public Relations efforts conducted by him over the past year with other organizations who have an interest in the foot and ankle. In addition, a brochure on the Foot and Ankle has just been published by the national office of APTA. He thanked the contributors to it and if anyone is interested, they are available for purchase from the APTA in the "Resource Center." Tom also thanked those who served in the SIG over the past year and honored them with a certificate of appreciation. Those honored included Steve Reischl as Vice Chair, and Michael Mueller and Jim Birke as members of the nominating committee. The *"Orthopaedic Practice"* newsletter of the Orthopaedic Section would like to have a contribution from the SIG for each of its quarterly publications. If anyone is interested in writing one, they should contact Tom McPoil.

Vice-Chair:
Steve Reischl reported on the status of programming at the current meeting as well future meetings. There will be a one-day workshop held before the 1996 national meeting of the APTA in Minneapolis, MN. The workshop is entitled: "Pressure Assessment in Physical Therapy." Suggestions for future programming and their format was solicited by Steve from the members who were present.

Secretary/Treasurer:
Mark Cornwall reported that $1254.55 from the $4670.00 budget of 1995 was spent. These expenditures were to support the speakers and officer's attendance at the CSM in Reno, NV. The same level of funding support for next year has been requested from the Orthopaedic Section. In addition, a page has been created on the world wide web for members to get information related to SIG activities. A list server (FOOT-L) has also been created to increase communication between individuals with information or questions on the foot and ankle.

Research:
Irene McClay reported on the results of the survey conducted by her committee regarding membership interest in research activities. There have been 21 responses to the survey so far. The results of this survey will be included on the SIG's web page for members to get access to. In addition, Irene is exploring possible funding sources for individuals to participate in research internships.

Practice:
Joe Tamaro reported on the status of the survey on foot and ankle terminology by various health professionals which his committee has been working on. Tom McPoil has charged his committee to develop a "common" terminology which can be voted on at our next meeting in Dallas, TX in 1997. This would then be submitted to other sections within the APTA for their approval.

Elections:
Elections were conducted for the office of Vice-Chair and two spots on the Nominating Committee. Steve Baitch, Joe Tamaro and Steve Reischl were running for the office of Vice-Chair. Michael Mueller and Debbie Nawoczenski were the candidates for the Nominating Committee. The results of the elections were announced by Irene McClay. They were as follows:
Vice-Chair: Steve Reischl
Nominating Committee: Michael Mueller and Debbie Nawoczenski

Adjourned: 1:25 pm

Respectfully Submitted by Mark Cornwall
Secretary/Treasurer, FASIG

FOOT-L DISCUSSION LIST
FOOT-L is a moderated List server open to anyone interested in the assessment and conservative treatment of the human foot and ankle. The purpose of this list is to encourage and foster greater communication among clinicians and researchers with an interest in foot and ankle problems. Individuals are encouraged to share information related to such things as problems they have, questions, job announcements or new equipment. Subscribers are expected to follow good e-mail and Internet etiquette and to refrain from using the list as a vehicle for personal gain. In other words, be polite and don't post overt commercial advertisements. This is a moderated list, which means that mail sent to the list name, FOOT-L@LISTS.NAU.EDU, will be forwarded to the list moderator for approval. If approved, the list owner will then distribute the message to the entire list.

Subscribing to this free list requires sending mail to the FOOT-L-REQUEST address (FOOT-L-REQUEST@LISTS.NAU.EDU). Include the command, SUBSCRIBE FOOT-L in the body of your message and nothing else.

To post items to all members of the list, send your message to FOOT-L@LISTS.NAU.EDU. Please include a brief statement concerning the messages content on the Subj:line. This will help recipients quickly identify items they are possibly interested in. Please try to remember that whatever you send to FOOT-L@LISTS.NAU.EDU is seen by everyone on the list.

I look forward to hearing from you and hope that you take advantage of this list service in your work. Thanks for joining.

Mark W. Cornwall, PhD, PT, CPed
List Moderator

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FASIG WWW HOME PAGE

If you didn't know already, the FASIG has its own page on the World Wide Web (WWW).

Information related to FASIG business and operations can be found there as well as information and links to other sites that might be of interest to you. Please surf on over and take a look.

Suggestions, contributions and any other kind of feedback is more than welcome. You can find the page at:
HTTP://JAN.UCC.NAU.EDU/~CORNWALL/FASIG/FASIG.HTML

Mark W. Cornwall, PT, PhD, CPed

Performing Arts Special Interest Group

Orthopaedic Section, APTA

Letter from the Executive Board of the Performing Arts Special Interest Group

Dear fellow PT's:

On behalf of the Performing Arts Special Interest Group, we would like to thank all who participated in the Combined Section Meeting in Atlanta, Georgia. We received positive feedback regarding the programming as well as many great suggestions to better meet the needs of the Performing Arts Special Interest Group. We are very excited to be a formal body with what we consider a strong working executive committee. We think you will agree when you see the proposed scheduling for Dallas in 1997. We would like to extend a warm invitation to all who feel they might have an interest in treatment of the performing artist. One of the objectives of the SIG is to disseminate information regarding treatment of the performing artist to a broad spectrum of therapists.

All cities and towns have a need for therapists who understand the demands and needs of performers, from the broadway musicals on the road, to the small dance and music studios. This coming year we have put together special programming that will address the basic science of dance and music medicine. Experience a dance class, hold a violin and learn the vocabulary. Learn how to become more involved with the arts community and gain the confidence of the artist. We also look forward to the presentation of new research that stemmed from the performing arts but is applicable to most fields of physical therapy. Lastly we hope to have an evening set aside to enjoy local entertainment from Dallas and a reception afterwards to socialize with fellow SIG members and potential SIG members. It is often at these events that valuable networking and unforgettable memories are made. We look forward to seeing you all in Dallas.

In 1998 we are looking forward to sharing programming time with other SIG's and other Sections within the APTA. If you have contacts or ideas, please communicate with our program chair, Marshall Hagins.

Sincerely,
Executive Board, Performing Arts SIG

Performing Arts SIG Officers

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In 1989 as many as 80 million Americans suffered chronic pain syndromes. Shoulder pain is one of the most predominant pain syndromes in this area and has a plethora of treatment modalities which vary from the conservative treatments of ice, heat, exercise and NSAIDs to numerous surgical interventions. These treatment selections are usually the result of the diagnosis of the cause of the problem and the specialty of the clinician making the diagnosis. Numerous experts agree that the best treatment approach to healthcare is a multidisciplinary team approach. The following case study describes such an approach in which an injured worker successfully completed a comprehensive pain management program:

GJ was a 50 year old, white male who presented to the multidisciplinary clinic with complaints of left shoulder pain for five years after involvement in an on-the-job motor vehicle accident. He had initially received treatment at a local hospital ER and was followed up by a local orthopaedic physician who diagnosed his condition as traumatic tendinitis. He was injected and referred to a local physical therapy clinic for 6 weeks of therapy. His therapy consisted of heat, ice, ultrasound, and exercises. This conservative program showed no improvement or increase in symptoms for the six week period. He was then referred by his orthopaedic physician to a local work hardening program for another 6 weeks. He failed to complete the program due to complaints of increased pain and decreased ROM/strength. He was discharged by his physician back to work with the recommendation he be placed at a job rated at the sedentary level. He was given an office job at this level which he was still performing but with increasing difficulty.

He stated the symptoms gradually had worsened over the past year, making it more difficult to raise his left arm over his head. He described his shoulder pain as a persistent, dull ache deep in the shoulder with an occasional sharp stabbing pain in the left deltoid and axillary areas. Shoulder pain increased with movement and subsided with rest. He expressed frustration that despite prompt interventions his condition not only did not improve but he had to accept a lower paying job to stay with his company. He reported he could not lift his grandchildren without suffering the next day nor could he play golf or cycle as he did prior to his injury. The patient stated he slept 6-7 hours a night but would be awakened 1-2 times a night by the pain.

The patient underwent consecutive evaluations by a physician, psychologist, physical therapist and nurse. At the team meeting the following observations were reported: the psychologist's evaluation revealed no mental disorder, his pain was graded as an 8 out of 10 on a 10 point pain visual analog scale (VAS); Beck Depression Questionnaire was 6, and his McGill Pain Questionnaire was 15. Subjective pain tolerances indicated severe to moderate impairment of activities of daily living secondary to pain.

The physical therapist performed a musculoskeletal exam which revealed muscle strength at wrist and elbows to be 5/5 yet strength at the left shoulder was 3/5 in the available ROM. No signs of inflammation were noted and no signs of tenderness were noted on palpation. Active and passive abduction was limited. (40 deg. AROM, 50 deg. PROM). External rotation was WNL but internal rotation was restricted to 20 deg. Cervical evaluation revealed normal ROM. Thoracic evaluation revealed restrictions at levels T1-T3.

Team recommendations were initially for biofeedback, participation in a behavior modification group, cervical steroid nerve blocks, and physical and occupational therapy. The therapy was to begin with a Functional Capacity Exam (FCE) then followed up with concentration on manual therapy techniques, closed kinetic chain, and functional activities utilizing Unloading Principles as described by Kelsey.

The patient initially underwent a FCE and was rated at the sedentary-light category. He received a cervical epidural steroid block 10 days after his initial evaluation. Physical and occupational therapy was started 2 days prior to his first injection. His first injection was 7 ml of 0.25% preservative-free bupivacaine and 80 mg preservative free methylprednisolone (Depo-Medrol). Five days later, GJ had 0% pain relief and a second injection was given and eight days later even with intensive PT and OT he reported a 20% reduction in pain. A third injection was given and upon his report six days later, the patient had 95% relief and no further injections were given. Re-evaluation revealed marked increase ROM of the left upper extremity with full abduction and internal rotation. The team, utilizing critical pathways for chronic pain, recommended continuation in the program. No further psychological or anesthesiological intervention was recommended but vocational counseling and PT/OT was. He began a four week work conditioning program followed up with a four week work hardening program after which the team would re-evaluate his progress.

A final FCE was completed at the three month mark, which revealed the patient was capable of performing at the medium level. He was found to have good overall work endurance, was cycling 20 miles 3-4 days per week and had resumed playing golf. Subjective pain tolerance scores indicated no impairment of activities of daily living secondary to pain. He also reported he could now pick up and play with his grandchildren without pain.

SUGGESTED READINGS:

Blossom, BN (1983): Role of Physical Therapist. SF Brena, SL Champman (eds), Management of Patients with Chronic Pain. S.P. Medical and Scientific Books, York, pp. 211-216.

Cronen MC, Waldman SD: Cervical Steroid Epidural Nerve Blocks in the Palliation of Pain Secondary to Intractable Tension-type Headaches. Journal of Pain and Symptom Management 1990;5:379-381.

Matsen FA, Bonica JJ. Pain in the Shoulder, Arm and Elbow. In: Bonica JJ. Management of Pain, Philadelphia Lee and Febiger, 1990.

PMSIG UPDATE

The PMSIG meeting was held at the CSM on February 17, 1996 and the following goals were adopted:

- Establish certification criteria and exam section for all specialties in pain management that could be added on to present exams.
- Adopt a mail ballot for upcoming elections.
- Facilitate a central liaison for APTA and Orthopaedic Section with International/National Pain Management Organizations.
- Establish a PMSIG newsletter by end of 1996.
- Develop a study course for the Orthopaedic Section on Pain Management.
- Function as a ready resource on Pain Management for the APTA and its members.

Further developments within the PMSIG include:

Liaisons with the American Academy of Pain Management (AAPM), International Association for the Study of Pain (IASP), and the American Pain Society have been instituted with the APTA and Gaetano Scotece, PT is serving as the liaison for the APTA.

Tom Watson, PT will assume the office as PMSIG Chairperson on June 10, 1996.

Any APTA member who wants to join the Pain Management SIG, to run for office or volunteer for a committee please contact the Orthopaedic Section at 1-800-444-3982 and submit your name.

Paris Distinguished Service Award

PURPOSE

1. To acknowledge and honor a most outstanding Orthopaedic Section member whose contributions to the Section are of exceptional and enduring value.
2. To provide an opportunity for the recipient to share his or her achievements and ideas with the membership through a lecture presented at an APTA Combined Sections Meeting.

ELIGIBILITY

1. The nominee must be a member of the Orthopaedic Section, APTA, Inc., who has made a distinguished contribution to the Section.
2. Members of the Executive Committee and members of the Awards Committee shall not be eligible for the award during their term of office.

CRITERIA FOR SELECTION

1. The Nominee shall have made substantial contributions to the Section in one or more of the following areas:
   a. Demonstrated prominent leadership in advancing the interests and objectives of the Section.
   b. Obtained professional recognition and respect for the Section's achievements.
   c. Advanced public awareness of orthopaedic physical therapy.
   d. Served as an accomplished role model, and provided incentive for other members to reach their highest potential.
   e. Utilized notable talents in writing, teaching, research, administration, and/or clinical practice to assist the Section and its membership in achieving their goals.
2. The nominee shall possess the ability to present a keynote lecture, as evidenced by:
   a. Acknowledged skills in the organization and presentation of written and oral communications of substantial length.
   b. Background and knowledge sufficient.

PROCEDURE FOR NOMINATION

1. Any member of the Orthopaedic Section may nominate candidates for the Award.
2. One original set and four duplicates of all materials submitted for each nomination must be received by the Administrative Director at the Section office by December 1, for consideration for the award in the following year.
3. The materials submitted for each nomination shall include the following:
   a. One support statement from the nominator, indicating reasons for the nomination, and clarifying the relationship between the nominator and nominee.
   b. Support statements from two professional colleagues.
   c. Support statement from two former or current Orthopaedic Section officers or committee chairs.
   d. The nominee's curriculum vitae.
4. The nomination materials should document examples of how the nominee fulfills the criteria for this award.

PROCEDURE FOR REVIEW AND SELECTION

1. Nomination materials shall be submitted to the Section office. The Section office will retain the original set of materials and will provide the Awards Committee with copies for review.
2. The Awards Committee will review the nominations and recommend the most qualified candidate to the Executive Committee.
3. The Executive committee will select the recipient.
4. Any member of the Awards or Executive Committees, who is closely associated with the nominee, will abstain from participating in the review and selection process.
5. The award will be presented only if there are qualified candidates, and one is selected.
6. Nomination materials are considered the property of the Awards Committee, who will maintain their confidentiality.
7. Nomination materials will not be returned. If any individual is not selected for the award in a given year, that individual may be nominated in subsequent years. The Section office will retain nomination materials for two years.

LECTURE

1. The recipient will present their lecture at a Section "Awards Session" at the APTA Combined Sections Meeting. The lecture should not last longer than thirty minutes.
2. The title of the lecture will be left to the discretion of the recipient.
3. The lecture should focus on the recipient's ideas and contributions to the Section and orthopaedic physical therapy.
4. The recipient is invited to submit a a paper based on the lecture for consideration for publication (pending review) in the *Journal of Orthopaedic and Sports Physical Therapy* OR submit the paper for publication in *Orthopaedic Physical Therapy Practice.*

NOTIFICATION OF THE AWARD

1. The President of the Section will notify the recipient by April 1st and obtain written confirmation of acceptance by May 1st.
2. The name of the recipient will be kept confidential until announced at the APTA Annual Conference.
3. The award will be presented at the APTA Combined Section s Meeting following presentation of the lecture.
4. Those nominees not selected will be so informed in writing.
5. The nominators or individuals not selected will receive a letter thanking them for their participation and informing them of the award recipient.

THE AWARD AND ITS PRESENTATION

1. The Orthopaedic Section will reimburse the recipient for round trip coach airfare from any site in the US. or Canada to the Combined Sections Meeting at which the lecture is presented, two days per diem consistent with the Section's current reimbursement rates and one day's conference registration.
2. On the occasion of the presentation of the lecture, the awardee will receive an appropriate plaque and an honorarium of $250.
3. The recipient's name and date of award will also be inscribed on a Distinguished Service Lecture Award plaque that is retained and displayed in the Section's headquarters.

Please submit any nominations to the Section office by December 1, 1996.

THE ORTHOPAEDIC SECTION, APTA, INC.
and the
Orthopaedic Section Foot & Ankle Special Interest Group
present:

1997 Combined Section Pre-Conference Course

FOOT ORTHOSES: THE SCIENTIFIC BASIS AND CLINICAL CONCEPTS

Wednesday, February 12, 1997 - Dallas, Texas

COURSE OBJECTIVE: The participant will learn the scientific basis for the use of foot orthoses and current clinical concepts in the design and prescription of foot orthoses.

INSTRUCTIONAL LEVEL: Various SUBJECT CODE: (12)

MORNING SESSION: The Scientific Basis for the Use of Foot Orthoses

8:00-8:15	Introduction
8:15-9:15	The Basis for the Use of Foot Orthoses: Functional Foot Mechanics Thomas McPoil, PhD, PT, ATC
9:15-10:15	The Premise for Abnormal Foot Function: *The Typical Pattern of Foot Movement During Walking* Mark Cornwall, PhD, PT, CPed
10:15-10:30	BREAK
10:30-11:30	The Essential Elements of Foot Orthoses Design: *Pathomechanics Affecting Foot Movement* Robert Donatelli, PhD, PT, OCS
11:30-12:30	Determining the Optimal Foot Orthoses Prescription: *The Foot and Ankle Examination* Michael Wooden, MS, PT, OCS
12:30-1:30	LUNCH (on your own)

AFTERNOON SESSION: The Design and Prescription of Foot Orthoses: Three Clinicians Viewpoints

1:30-2:30	First Clinician - Robert Donatelli, PhD, PT, OCS
2:30-3:30	Second Clinician - Michael Wooden, MS, PT, OCS
3:30-3:45	BREAK
3:45-4:45	Third Clinician - Thomas McPoil, PhD, PT, ATC
4:45-5:45	Panel Discussion with Questions from the Audience
5:45-6:00	Summary and Adjourn

TUITION:
Orthopaedic Section Members: $125.00
APTA Members: $175.00
Non-APTA Members: $200.00

Cancellation received in writing prior to the course date will be refunded in full minus a 20% administration fee. Absolutely no refunds will be given after the start of the course.

To register, complete the form below, detach and mail to: Orthopaedic Section, APTA, Inc., 2920 East Avenue South, La Crosse, WI 54601, 800-444-3982, or FAX registration and VISA or MasterCard number to: 608-788-3965.

FOOT ORTHOSES: THE SCIENTIFIC BASIS AND CLINICAL CONCEPTS

Name: _____

Address: _____

City, State, Zip: _____

Daytime Phone: _____ APTA I.D. No.: _____

Enclosed is my registration fee in the amount of $ _____

Make checks payable to the Orthopaedic Section, APTA, Inc.

☐ Orthopaedic Section Member
☐ APTA Member ☐ Non-APTA Member
☐ Check here if you have special needs that are regulated by the Americans with Disabilities Act.

Visa/MC (circle one) # _____

Expiration Date _____

Signature _____

Orthopaedic Physical Therapy Practice
American Physical Therapy Association
2920 East Avenue South
La Crosse, WI 54601