ORTHOPAEDIC PHYSICAL THERAPY PRACTICE

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VOL. 12, NO. 1 2000

ORTHOPAEDIC SECTION • AMERICAN PHYSICAL THERAPY ASSOCIATION •

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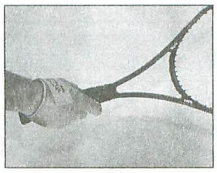

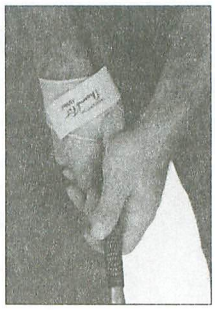

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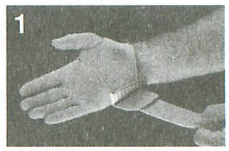

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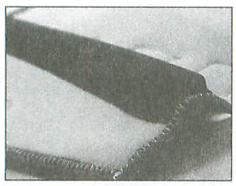

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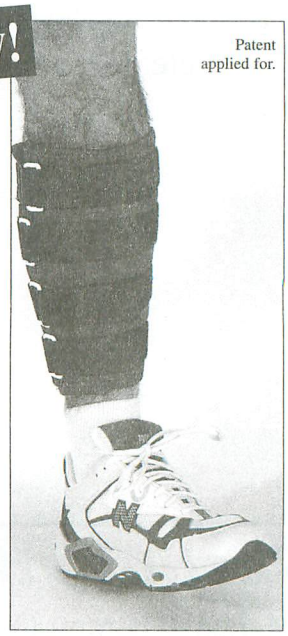

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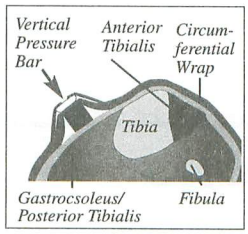

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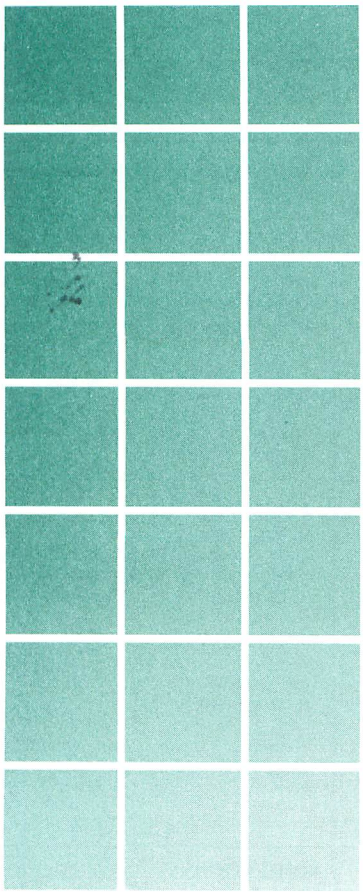

IN THIS ISSUE

REGULAR FEATURES

MISSION

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

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

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Editor's Message

CSM 2000 New Orleans

Happy 2000! Although this will reach you in April, this is the first issue of *OP* for the year. This issue is full of information from the recent Combined Sections Meeting (CSM). CSM is a great meeting every year, but this year broke all records in New Orleans with over 4600 attendees. Programming was very successful with most of the rooms overflowing. Luckily, you can order an audiotape of the sessions you really liked or those you were unable to attend. Lola Rosenbaum and Paul Howard, Chair and Co-chair of the Education Program Committee, respectively, are to be congratulated for their hard work, as are each member of the committee (Ellen Hamilton and Gary Shankman) and each of the SIG Program Chairs. Without the work of these very dedicated volunteers, CSM would not be the success that it is. I would like to thank you all for providing us with such wonderful educational opportunities. I would also like to thank Sharon Klinski, Managing Editor of *OP,* for all of her tireless efforts to get this publication (and many others) to press. Thank you Sharon for your dedication and great work.

The week in New Orleans was a busy one, with much Section business accomplished. This issue of *OP* is dedicated to the business of the Section and its Special Interest Groups (SIGs).

If you were not able to attend CSM and want to get up-to-date with what's going on with the Section, the Annual Report is in this issue, as well as Board and Business Meeting Minutes and committee reports. At the Section Business Meeting, 4 motions from the floor were passed (see minutes, page 25). These motions reflect issues of importance to the membership and charge the Board to investigate these topics. It was great to have such an interactive meeting and to see the membership provide direction to the Board on these issues.

The Section, along with the APTA Board of Directors, will again cosponsor a RC to be presented the House of Delegates concerning direct interventions exclusively performed by physical therapists. This RC deals primarily with manipulation and sharp debridement. If these are areas of interest to you, be sure to contact the Section office or one of the delegates from your Chapter for more details. The proposed Vision Statement was also discussed at an open forum at CSM. If you have not read the revised version, contact APTA or one of your local delegates for the complete statement. For further discussion, see the President' Message on page 8. The Vision Statement continues to generate discussion and will likely be a hot topic at the House this year.

The SIG newsletters are packed with information. Each contains their respective minutes of the business meetings held in New Orleans and election results. The Orthopaedic Section SIGs are alive and well! These groups do tremendous amounts of work and put together terrific programming for the membership. They also serve as a resource to persons looking for practitioners in particular areas of practice or to therapists who want to expand or redirect their own area of practice. Thanks to the SIG Boards for a job well done.

In addition to business, CSM is a time to recognize the achievements of some of our distinguished members. The Awards Ceremony on Saturday night was quite special. Awards were given to Mark Werneke, PT, MS, Dip MDT, Rose Award for Excellence in Research; Guy Simoneau, PT, PhD, ATC, Award for Excellence in Teaching Orthopedic Physical Therapy; and Matthew Crill, MS, CSCS, Outstanding Physical Therapy Student Award. Mark's speech is printed on page 24. Trevor Carlson was recognized as the Student Guest winner. Congratulations to all recipients!

The Paris Distinguished Service Award was given posthumously to Bob Burles. (See Memorial, *OP*, 11;1,1999). Bob's wife Marion and 2 of their 3 children, Cathy and Michael, attended the ceremony and accepted the award. In addition, John Medeiros paid tribute to Bob. Those of us present were treated with a wonderful video about Bob that was put together by his family. Please be sure to read the article detailing the event on page 17. Needless to say, Bob was a very special man to all who knew him. Thanks to Bob's family for sharing him with us.

This issue of *OP* also features an article by Jill Binkley detailing the process of forming a working research network and the benefits such a network can provide. A new column, "Practice Affairs Corner," by Steve McDavitt, makes its debut in this issue as well. Steve and Helene Fearon, Co-chairs of the Practice Committee, have been busy at work assisting members and Chapters with legislative efforts, particularly related to manual therapy issues. Steve's article revisits the issue of defending skilled practice. I hope you find it thought provoking.

Speaking of thought provoking, in the last issue of *OP* Rennie Maeda provided us with a "Letter to the Editor." In this issue, we have a dialog of sorts. Two persons responded to Mr. Maeda's letter, and in turn, he provided a response. I think this is evidence that his letter was in fact thought provoking. Thank you Mr. Maeda. We welcome this sort of discussion in *OP* and invite others to participate. Feel free to submit your commentaries at any time.

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

President's Message

Is There A Doctor In The House?

Just prior to CSM 2000, the APTA Board of Directors (BOD) disseminated a revised draft of the APTA vision sentence and statement. The original draft was printed in OP Volume 11, Number 3, 1999. A comparison of the recent version and the original reveals a number of changes, but one part that does remain the same is the statement;"physical therapy will be provided by doctors of physical therapy...." I believe the public declaration of this phrase is the key element of the vision statement. I also believe the debate of whether "doctors of physical therapy" should be included or not is a moot point. The decision was already made when the *Guide to Physical Therapist Practice,*[1] including the Patient/Client Management Model,was adopted. The 5 elements of this model include examination, evaluation, diagnosis, prognosis, and intervention. The responsibilities associated with these 5 elements are consistent with the responsibilities assumed by existing health professionals who hold the title of doctor. We did everything in the *Guide* but state physical therapy is provided by doctors of physical therapy. Now it's time to make the public declaration.

Detractors of this statement say "who do we think we are, real doctors (MDs, DOs, etc.)?" I also hear "this won't get us any more professional respect" and that "we'll expect higher salaries and will only price ourselves out of the market" so we are better off with our current titles. The vision statement says nothing about doctors of physical therapy practicing allopathic or osteopathic medicine. Why would we want to? There are plenty of MDs and DOs already providing these services. Will calling ourselves doctor guarantee respect from others? Of course not! Respect worth having is respect that has been earned. Our actions as professionals and as a profession will determine whether we will be respected or not. Lastly, future doctors of physical therapy may expect higher salaries, but what we want doesn't always match what we get. Our market value and our entrepreneurial abilities will dictate our salaries, not our titles.

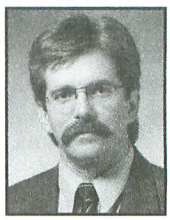
Declaring that physical therapy will be provided by doctors of physical therapy raises the bar by which we will be judged. This challenge is necessary for the evolution of our profession to continue in the direction that will be of the greatest benefit to those we serve. While I applaud APTA's effort to gather feedback and opinions of the drafts, I hope our "vision" debate comes to an end soon so we can begin the job that awaits us.

Etc.

1. Thank you office staff, committee chairs and officers for the tremendous effort prior to and during CSM.
2. Thank you John Medeiros for leading the tribute to Paris Service Award recipient, the late Bob Burles.

REFERENCE

1. Guide to Physical Therapist Practice. *Phys Ther.* 1997;77:1163-1650.



William G. Boissonnault, PT, MS, DPT
President

AAOMPT 2000 — FIRST CALL FOR ABSTRACTS

The 6th Annual Conference of the American Academy of Orthopaedic Manual Physical Therapists will be held in the fall of 2000. It promises to be an exciting event, which will include the Distinguished Researcher and Clinician Dr. Gordon Waddell author of The Back Pain Revolution. Interested individuals are invited to submit abstracts for presentation in slide or poster format. The AAOMPT research committee chairman must receive the abstract and 2 photocopies, by June 1, 2000. Abstracts received after this date will be returned. You will be notified of the acceptance/rejection of your abstracts in July of 2000. If you have any questions call the research committee chairman at (210) 221-8410 or -6167 or email at: Timothy.Flynn@cen.amedd.army.mil

Content. The Academy is soliciting all avenues of research inquiry from case-report and case-series up to clinical trials. The Academy is particularly interested in evaluating efficacy of intervention strategies using randomized-controlled clinical trials. The abstract should include 1) Purpose; 2) Subjects; 3) Method; 4) Analyses; 5) Results; 6) Conclusions; 7) Clinical Relevance.

Publication. The accepted abstracts will be published in The Journal of Manual & Manipulative Therapy, which has readership in over 40 countries.

Submission Format. The format for the submitted abstracts is as follows:
The abstract should fit on one page with a one inch margin all round. The text should be typed as one continuous paragraph. Type the title of the research in ALL CAPS at the top of the page followed by the authors' names. Immediately following the names, type the institution, city, and state where the research was done. Please include a current email address where you can be contacted. Also include a computer diskette with the abstract in MS Word format.

Presentation. The presentation of the accepted research will be in either a slide or poster session. The slide session will be limited to 15 minutes followed by a 5-minute discussion, this session will be primarily for research reports and randomized clinical trials. The poster session will include a viewing and question answer period and will be primarily for case report/series.

Abstract Award. The author of the abstract deemed of the highest quality of those submitted will be awarded the Annual AAOMPT Excellence in Research Award. This award will consist of an award certificate and reimbursement of the conference registration fee.

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Orthopaedic Section, APTA Annual Report 1999

MISSION

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

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

VISION

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

Annual Report 1999

William G. Boissonnault, PT, MS, DPT, President

1999 marked the 25th anniversary of the Orthopaedic Section. The events of our first 25 years were well chronicled by Stanley Paris, Dorothy Santi, Carolyn Wadsworth, Nancy White, and Joe Farrell in the 1999 issues of *Orthopaedic Physical Therapy Practice (OP)*. 1999 also marked the 20th anniversary of JOSPT. The JOSPT, a joint venture with the Sports Section, began its newest chapter under the direction of a new JOSPT Board of Directors and Editor-in Chief, Dr. Richard DiFabio. See the JOSPT Inc. bylaws on page 9 in this issue of *OP*.

As it did for 1998, this annual report summarizes the Section's activities in 1999. A detailed description of all of the Section's business can be found in the 4 1999 issues of *OP*. A number of initiatives were instituted and a number carried over from previous years. Our success stemmed from the efforts of grassroots membership, our dynamite office staff, and a committed group of committee chairs, members, and officers. I thank each and every one of you for your commitment to the profession.

SECTION GOALS AND ACTIVITIES

1. *Facilitate continued professional development in orthopaedic physical therapy practice.*

The priority of providing members quality, accessible, and affordable education remains. Home study course topics for 1999 included: Diagnostic Imaging of Bones and Joints, Orthopaedic Interventions with Seniors, and Managing Lumbar Spine Dysfunction. These courses will remain available for another 4 years. Our continuing education courses were extremely well attended. The courses offered included: Canine Physical Therapy I; Foot and Ankle Dysfunction; and Evaluation and Management of Diabetic, Arthritic, and Orthopaedic Disorders. In addition, the Section was cosponsor for the American Academy of Orthopaedic Manual Physical Therapists 1999 conference. Excellent articles relevant to clinical practice continue to be published in *OP* and *JOSPT*.

The number of orthopaedic certified specialists continues to climb as our support for the process continues. There are now over 1200 Orthopaedic certified specialists. Orthopaedic Clinical Residency Programs took advantage of the Section grants allocated for covering the APTA credentialing application fee.

2. *Create dynamic leadership development programs for members.*

We continue to sponsor the PT and PTA Student Award with both awardees being funded to Combined Sections Meeting. A member of the nominating and finance committee are funded to attend the Section Fall BOD Meeting, and we continue to fund 4 to 5 Section officers and committee chairs/members to attend the APTA's Component Leadership Seminar. In addition, our 1999 Fall BOD Meeting was held in Alexandria, VA. We spent 1-full day meeting with APTA staff to discuss issues of mutual concern/interest, and we left with a better understanding of how APTA functions. Lastly, to involve the grassroots membership in Section activities, we continued to develop the media spokesperson network and the legislative network.

3. *Provide leadership for fostering and directing clinical research to establish outcomes effectiveness and efficacy of orthopaedic physical therapy.*

The Section contributed $100,000 to the Foundation for Physical Therapy for the provision of 2 $40,000 grants. As in previous years, the Section provided funding for our clinical research grant program ($5,000 and $1,000 grants). The growth and development of the JOSPT remains a priority as our primary means of disseminating scientific and clinical information germane to orthopaedic and sports physical therapy practice.

4. *Promote knowledge of and provide support for physical therapists as our entry point in the management of musculoskeletal dysfunction.*

The Section's membership and orthopaedic physical therapy practice were represented at the physician assistant's conference in Atlanta, Georgia. Terry Randall, PR Committee Chair, was invited to attend the Physician Assistants in Orthopaedic Surgery Business Meeting and the Liaison-networking Meeting. The Section also had representation at the American College of Nurse Practitioners in Nashville, Tennessee. These opportunities allowed us to promote the orthopaedic physical therapists role in the management of orthopaedic conditions. Lastly, under the direction of our Animal PT SIG the Section was represented at the First International Symposium on Rehabilitation and Physical Therapy in Veterinary Medicine in Oregon.

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

The Practice Committee continues to be a valued and often-used resource for the many states embroiled in chiropractic legislative activities. The PR Committee has developed a governmental affairs network made up of Section members located in each chapter. These individuals will be the conduits through which legislative information can flow to and from the Section. In response to the ever-increasing chiropractic legislative activity, the Orthopaedic Section spearheaded a 1-day meeting with APTA staff and representatives from the AAOMPT, APTA chapters, and the academic community to discuss manual therapy legislative issues. The outcome of the meeting was a strategic plan, which emphasized legislative, regulatory, and educational initiatives designed to assist chapters in the upcoming years.

6. *Utilize technological advancements to educate and communicate with membership and facilitate Section governance.*

The Section's Internet Home Page (orthopt.org) continues to be developed under the tutelage of Tara Fredrickson, Executive Assistant. The PR Committee has recently developed the public relations section of the web site. Please visit our site!

7. *Generate alternate sources of revenue to increase benefits to members, protect fiscal solvency, and control costs.*

Our home study courses and Section educational programming continue to provide us with the bulk of our nondues revenue. We have also begun to investigate the feasibility of a charitable giving program with the Section being the beneficiary of such donations. These donations could be used to fund a number of large initiatives consistent with our mission.

8. *Attain international recognition for the Orthopaedic Section.*

This past year the Section offered "retired" (over 5 years old) home study courses to 25 overseas physical therapy programs. Each of the following country's programs was sent copies: Vietnam, Transkei, India, Surinam, St. Lucia, El Salvador, Zanzibar, and Bhuttan. The AAOMPT remains the Orthopaedic Section liaison to the IFOMT. Allen Press, Inc. continues to market the JOSPT in foreign markets.

9. *Maintain current annual membership growth rate of 2%.*

Two percent growth remains our goal, but the challenge to do so is escalating. APTA membership has decreased considerably and individuals cannot join the Section without first joining APTA and his/her chapter. Our membership did not grow in 1999, as our numbers were approximately the same at the end of 1999 as they were in 1998. But our goal is to have membership increase, not just remain at a constant level, so we have reinstituted a Membership Committee which will be chaired by Michael Wooden.

10. *Develop and maintain a record of Section history.*

The Section archive has been developed and the activities of our first 25 years have been chronicled in *OP* throughout 1999. Dorothy Santi has been appointed the Section Historian, and she will work with the Section office staff to maintain our archives. ■

JOSPT: The Journey Continues

December 31, 1999 marked the end of the *Journal of Orthopaedic and Sports Physical Therapy's (JOSPT)* 20th year of existence. The 20-year time capsule represents a rich and relatively stable history. In the first 19 years, the JOSPT was published by a single company Williams and Wilkins who collaborated with only 2 journal offices. La Crosse, Wisconsin was the initial home base for the Journal and the second office was located in Iowa City, Iowa. During these years, the Journal's Editorial Board was confidently led by the late James Gould and George Davis and most recently by Dr. Gary Smidt.

For the JOSPT, 1999 will forever be remembered as the year of the transition. The January issue was the first published under the leadership of a new Editorial Board headed by Dr. Richard DiFabio who collaborated with Allen Press, the Journal's new publishing company. The Journal office had also returned to La Crosse, Wisconsin opening in July 1998. One other important change also occurred, the Orthopaedic and Sports Sections created an organization called the Journal of Orthopaedic and Sports Physical Therapy, Inc. (JOSPT, Inc)

The primary responsibility of JOSPT Inc. is to oversee the management and production of the JOSPT. In the past, once the publishing and Editor-in-Chief contracts were signed, the Sections represented by their respective presidents and treasurers served primarily as advisors on the JOSPT Advisory Council. In 1996, the Sections' Executive Committees decided this role was inadequate to meet the Sections' needs related to the Journal. We believe this new management structure more closely ties the Journal to the Sections' membership and will facilitate the attainment of our vision for the Journal. The JOSPT, Inc is overseen by a Board of Directors (Board). The Board consists of the Orthopaedic and Sports Section's Presidents, (One Section President serves as Board President and the other as Board Vice President) and 2 member at large positions. One member at large position will be filled by an executive committee member from either the Orthopaedic or Sports Sections and the other will be filled by someone outside the Sections' Executive Committees. Currently Peter Loubert, PT, PhD, ATC, is serving (a 3-year term) the Sections in this capacity. The Board serves many functions as outlined in the following JOSPT, Inc. Bylaws. One example of our roles is what occurred at a recent meeting. On October 8, 1999, in LaCrosse, WI Mark De Carlo and I met with Dr. DiFabio and the JOSPT office staff. The purpose was to discuss office and journal production issues and also to do performance reviews for Dr. DiFabio and Gerald Cook the Editorial Assistant and Office Manager. For the performance reviews, we collected information from Editorial Board members and JOSPT authors to help us appraise performance and also set goals and objectives for the upcoming year. This type of review will occur annually,

We are confident that all the pieces are in place to insure the continued growth and success of the JOSPT. A dedicated Editorial Board has worked extremely hard since September 1998 to assist authors in publishing scholarly papers that will advance the science and practice of orthopaedic and sports physical therapy. We have a dedicated team of office staff, who effectively link the authors with the Editorial Board and Allen Press, Inc. The Orthopaedic and Sports Sections' Executive Committees are committed to the growth and success of your publication, the JOSPT. We present the following bylaws for your review and ask that you read them carefully and share your comments, questions, or concerns with us.

Thank you,
Bill Boissonnault, PT, MS, DPT
President, Orthopaedic Section, APTA, Inc.

Mark DeCarlo, PT, MHA, SCS, ATC
President, Sports Physical Therapy Section, APTA, Inc.

THE JOURNAL OF ORTHOPAEDIC AND SPORTS PHYSICAL THERAPY, INC. BYLAWS

ARTICLE I. NAME

The name of the organization is the *Journal of Orthopaedic and Sports Physical Therapy*, Incorporated, hereinafter referred to as JOSPT, Inc. which is owned and operated by the Orthopaedic Section and the Sports Physical Therapy Section of the American Physical Therapy Association, hereinafter referred to as the OSPTS (the "Members").

ARTICLE II. PURPOSE

The JOSPT, Inc. is organized exclusively for the purpose of publishing a scientific journal to educate the medical community concerning the latest developments in orthopaedic and sports physical therapy and to oversee the management and production of the *Journal of Orthopaedic and Sports Physical Therapy* (JOSPT) of the Orthopaedic Section of the American Physical Therapy Association, Inc., and the Sports Physical Therapy Section of the American Physical Therapy Association, Inc.

ARTICLE III. OBJECTIVES

Produce a scholarly and peer-reviewed journal that advances the science and practice of orthopaedic and sports physical therapy. The science and practice of orthopaedic and sports physical therapy includes, but is not limited to, kinesiology, biomechanics, motor behavior, fitness, clinical outcomes, gerontology, epidemiology, and neuroscience.

ARTICLE IV. BOARD OF DIRECTORS

Section 1: Composition

A. The Board of Directors of JOPST, Inc. hereinafter referred to as the Board, shall consist of the president, who will also hold the position of treasurer, vice president, who will also hold the position of secretary, and two members-at-large.
B. Advisory members of the Board shall include the Editor-in-Chief, Managing Editor, and a representative from the publishing company under contract.

Section 2: Appointments to the Board

A. At the conclusion of the American Physical Therapy Association Combined Sections Meeting in 1999, the incumbent president of the Orthopaedic Section will serve as president of the Board. Upon completion of the first term, the position of president will be assumed by the president of the Sports Physical Therapy Section and will continue to alternate in future years.
B. At the conclusion of the American Physical Therapy Association Combined Sections Meeting in 1999, the

incumbent president of the Sports Physical Therapy Section will serve as vice president of the Board. Upon completion of the first term, the position of vice president will be assumed by the incumbent president of the Orthopaedic Section and will continue to alternate in future years.

C. One member-at-large position on the Board shall be appointed from the Section opposite that which the president represents. The Executive Committee of that Section shall appoint a member of their Executive Committee to serve as member-at-large.

D. The second member-at-large position shall be appointed by the president, vice president, and member-at-large of the Board. This person must have a Doctoral degree and an academic appointment with teaching and research experience in a field related to physical therapy. This appointment will provide a scholarly influence to the Board. The Advisory members of the Boards, as well as the OSPTS Executive Committees, may provide input as to this appointment. This person cannot be a member of the JOSPT, Inc. Editorial Board or a member of the OSPTS Executive Committee.

E. In order to maintain an appropriate level of experience on the Board, the immediate past president of the Orthopaedic Section or president of the Sports Physical Therapy Section may serve as a non-voting member of the Board for a period of one year upon completion of their term on the Orthopaedic or Sports Physical Therapy Section Executive Committee.

Section 3: Terms of Appointment to the Board

A. At the conclusion of the American Physical Therapy Association Combined Sections Meeting in 1999, the president, vice president and member-at-large appointed from OSPTS, shall begin serving a one year term.

B. The member-at-large appointed from the Section opposite that which the president represents shall go off the Board at the conclusion of their term on the Executive Committee of the Section. The Executive Committee of that Section shall appoint a replacement.

C. The member-at-large, appointed from the Board with academic preparation, shall serve a three-year term and shall not serve more than two consecutive terms on the Board.

Section 4: Voting on the Board

A. The president, vice president, and members-at-large shall have the right to vote.

B. A voting majority shall consist of three-fourths (3/4) of the voting Board members present at the meeting. If only three members of the Board are in attendance a unanimous vote (3) is required.

C. Advisory members of the Board shall have all rights except the right to vote.

Section 5: Duties and Responsibilities of the Board

The Board shall oversee the operations of JOSPT, Inc. and shall make and enforce policies, which are consistent with the Bylaws. To ensure appropriate operation of JOSPT, Inc. the Board shall have responsibility for:

A. Approving the annual budget to include those expenses relating to the editorial board as well as JOSPT, Inc. office expenses.

B. Developing, reviewing and approving the memorandum of agreement with the Editor-in-Chief and the Managing Editor.

C. Approving the renewal of the publishing agreement between JOSPT, Inc. and the current publisher.

D. Informing the OSPTS Executive Committees in the event of a vacancy in the JOSPT, Inc. Editor-in-Chief position. The OSPTS shall appoint a search committee to find a replacement. Representation on the Search Committee from the Orthopaedic Section and the Sports Physical Therapy Section will reflect current membership distribution.

E. Making recommendations to the OSPTS regarding consideration to investigate other publishing options.

F. Hiring the Managing Editor.

G. Providing office space for the JOSPT, Inc. including negotiating, entering into and renewing a lease for JOSPT, Inc. office space.

Section 6: Duties and Responsibilities of the JOSPT Advisory Board Members

A. Editor-in-Chief shall:
   1. Attend the regularly scheduled meetings of the Board.
   2. Serve in an advisory role to the Board.
   3. Make recommendations to the Board in appointing the member-at-large position.

B. Managing Editor shall:
   1. Attend the regularly scheduled meeting of the Board.
   2. Serve in an advisory role to the Board.
   3. Keep the official minutes of all Board meetings.

C. Publishing Company Representative shall:
   1. Attend the regularly scheduled meetings of the Board.
   2. Serve in an advisory role to the Board.

Section 7: Meetings

A. Regular Meetings
   The Board will meet two times per year at the American Physical Therapy Association Combined Sections Meeting and Annual Conference and Exposition.

B. Special Meetings
   1. A special meeting may be called upon written petition of a majority of the voting members of the Board.
   2. Additional Board meetings may be held during the course of the calendar year as deemed necessary by the Board.

C. Notice Requirements
   Notice of the time and place of meetings shall be determined by the president of the Board and conveyed to other members of the Board in a timely manner.

D. Quorum
   A quorum shall consist of three-fourths (3/4) of the voting Board members present at a meeting.

ARTICLE V. FINANCE

Section 1: Fiscal Year

The fiscal year of JOSPT, Inc. shall be the calendar year.

Section 2: Annual Budget Process

The Editor-in-Chief and Managing Editor shall submit to the Board a combined budget, to include editorial board and office expenses, by August 15 of each year. The Board is required to provide final approval of the annual budget by November 1 of each year.

Section 3: OSPTS Contributions

The OSPTS will provide revenue to the JOSPT, Inc. on a monthly basis. The total contributions from the OSPTS will be established by the approved annual budget. The Section contributions will be equal to the percent of each Section's membership at the beginning of each calendar year. If additional contributions are required for the operation

of JOSPT, Inc. the amount of each Section's contribution will be equal to the percent of each Section's membership at that point in time.

Section 4: Limitations on Expenses

All expenses associated with the operation of JOSPT, Inc. shall be according to the approved annual budget. Any expenses falling outside of the approved annual budget shall be brought before the president and vice president of the Board.

ARTICLE VI. DISSOLUTION

Section 1:

JOSPT, Inc. may dissolve subject to a recommendation by the JOSPT, Inc. Board of Directors. No less than three-fourths (3/4) vote of the members of the OSPTS Executive Committees would be required to determine if dissolution would occur.

Section 2:

In the event that JOSPT, Inc. is dissolved, all property and records shall, after payment of its bona fide debts, be conveyed to the OSPTS based on a percentage split equal to the number of members in each Section at the time of dissolution.

ARTICLE VII. PARLIMENTARY AUTHORITY

The rules contained in the current edition of *Robert's Rules of Order Newly Revised* shall govern JOSPT, Inc. in all cases to which they are applicable and in which they are not inconsistent with these Bylaws and any rules of order adopted by JOSPT, Inc.

ARTICLE VIII. AMENDMENTS

Section 1:

JOSPT, Inc. Bylaw changes will be recommended by the JOSPT, Inc. Board of Directors. The proposed amended Bylaws must be approved by no less than three-fourths (¾) vote of the members of the OSPTS Executive Committees.

Section 2:

In the event that OSPTS Bylaws are amended so as to require amendment to JOSPT, Inc. Bylaws, the Board president shall prepare the necessary amendments and submit them to the Board. Such changes in bylaws mandated by the OSPTS will be automatically adopted by the Board.

ARTICLE IX. OSPTS AS HIGHER AUTHORITY

In addition to these JOSPT, Inc. Bylaws, the Board is accountable to the OSPTS Executive Committees. ■

JOSPT

The North American Orthopaedic Rehabilitation Research Network*

Jill Binkley, PT, MSc, FAOMPT
Dan Riddle, PT, PhD

The North American Orthopaedic Rehabilitation Research Network was formed in response to needs expressed by researchers and clinicians. Researchers often have considerable difficulty linking up with clinicians committed to being involved with clinical trials. One of the greatest obstacles in clinical research is obtaining enough subjects to complete a trial and report the results in a reasonable length of time. Many clinicians find that involvement in research is a rewarding contribution to the profession but do not have the time and/or expertise to develop studies and collect data on large numbers of patients. The network is designed solely to promote research in the profession. Participation is entirely voluntary.

The network has 6 members who are primarily researchers and 24 members who are primarily clinicians. Several of the clinicians are in administrative positions in their clinical facility, but not all clinicians have an administrative role. In all cases, clinicians have sought support from the administrators and colleagues in their clinical setting. The number of clinics committed means that each clinic can collect data on a small number of patients over a relatively short period of time. For example, each clinic may be asked to collect data on 5 to 15 patients for a month or two.

Each project has a designated principal investigator(s). Any one of the network coordinators or member clinicians may lead a project. The 3 projects to date have been led by one of the research coordinators. In order to ensure a high standard of quality of research conducted in the network, all members have committed to presentation and/or publication of completed work in a peer-reviewed journal. In addition, the 6 research coordinators provide informal review of projects prior to implementing data collection in the network. There is an understanding that network members' contributions will be acknowledged in a standard format for all presentations and/or publications.

All projects are reviewed by a research ethics committee. This may be the ethics committee associated with the network that is based in Dahlonega or through an institution deemed by the principal investigator (for example, a university-based committee). The ethics review committee of the network does not supercede any institutional review boards and, depending on the clinical setting, clinicians may be required to obtain ethics approval at their own institution.

To date, we have completed 3 projects. The first was the examination of the measurement properties of the Lower Extremity Functional Scale, published March 1999 in *Physical Therapy.* The second project involved the testing of a scale for measuring function in patients with patellofemoral syndrome. The third project tested a new back pain scale, The Low Back Pain Scale, in comparison to existing scales. This paper is currently under review by the *Journal of Rheumatology.*

Other activities of the North American Orthopedic Rehabilitation Research Network include the sponsorship of an edition of *Orthopaedic Physical Therapy Practice* in the winter of 1999. Network members collaborated on an issue dedicated to evidence-based practice. This was also done in *The Orthopaedic Division Review*, a similar publication, in Canada.

We are currently working with the Orthopaedic Section to set up a network web page. We have found that communication among clinics can be difficult, and we believe that a web page may serve a dual purpose for the network. The web page can serve to communicate to member clinics about the progress of research projects and it may also serve as a way of sending data from clinics to research coordinators. We also send a network newsletter to members and the web page could serve this function as well. In addition, the web page will have information for other physical therapists interested in clinical research and setting up their own research network. Information on our network, institutional review boards, and grant sources may be accessed through the web page.

We in the network believe that a research network is one cost-effective way of collecting research data on large numbers of subjects with minimal effort in each individual clinic. In addition, we believe that evidence-based practice is enhanced through membership in the network, as evidenced by increasing use of outcome measures in clinical practices. The quality of our projects is maximized through our informal project review process that is carried out in an atmosphere of mutual respect and collegiality. Network members from both countries have utilized other members for clinical and research advice, and in a few instances, network contacts have been used in employment searches. Section members may benefit by using our network as a model in setting up more research networks around the country.

*Network Members: Brad Balsor, PT, St. Joseph's Hospital, Hamilton, ON; Paul Beattie, PhD, PT, Department of Orthopaedics, University of Rochester, Rochester, NY; Andrew Berk, PT, Summit Injury Management, Victoria, BC; Jill Binkley, PT, FAAOMPT, FCAMT, Appalachian Physical Therapy, Dahlonega, GA; Susan Brenneman, PT, Penn Therapy and Fitness, Philadelphia, PA; Linda Brett, PT, Kakabeka Physiotherapy, Kakabeka Falls, ON; Jane Burns, PT, Pacific Coast Rehabilitation Center, Vancouver, BC; Bert Chesworth, PT, FCAMT, University of Western Ontario, London, ON; Doug Conroy, PT, ATC, Conroy Orthopaedic and Sports Physical Therapy, Flossmoor, IL; Robert Feehley, PT, OCS, Baltimore Sports Rehab, Baltimore, MD; Karen Hayes, PhD, PT, Program in Physical Therapy, Northwestern University Medical School, Chicago, IL; Michael Kelo, PT, OCS, Sheltering Arms Physical Rehabilitation Hospital, Chester, VA; Carmen Kirkness, PT, McGill University, Montreal, QUE; Kim Kramer, PT, Sartori Hospital, Cedar Falls, IA; Jim Krzaczek, PT, OCS, Life Care Medical Center, Glassboro, NJ; Sue Ann Lott, PT, Appalachian Physical Therapy, Dahlonega, GA; Karen Orlando, PT, Physiotherapy on Bay, Toronto, ON; Beverley Padfield, PT, FCAMT, Four Counties Health Services, Newbury, ON; Corinne Roos, PT, Kettle Creek Physiotherapy and Sports Injuries Clinic, St. Thomas, ON; Linda Nolte Smith, PT, MTC, Park at Stony Point Physical Therapy, Richmond, VA; Dan Riddle, PhD, PT, Virginia Commonwealth University, Richmond, VA; Gregory Spadoni, PT, ProActive Physiotherapy, Hamilton, ON; Diane Stratford, PT, West End Physiotherapy Clinic, Hamilton, ON; Paul Stratford, MSc, PT, McMaster University, Hamilton, ON; Linda Watts, PT, Algoma Physical Rehabilitation Clinic, Sault Ste. Marie, ON; Michael Westaway, PT, FCAMT, Canadian Sport Rehabilitation Institute, Calgary, AL; Myra Westaway, PT, HSC, Lindsay Park Sport Rehab, Calgary, AL.

Dear Rennie:

I read your Letter to the Editor with much interest and certainly agree that we ought to be defining problems in terms that are meaningful to ourselves and communicating those to others rather than try to conceptualize low back problems in some other profession's terms as if they spoke a universal language. I do believe, however, that we have a practical issue to contend with in PT characterizations of the problem. When I was teaching at a university in the U. S., we ran into this problem with an advanced master's student who was going to compare mobilization to ultrasound (the latter being a sort of "control" group) in "pure" low back pain patients. This student had a busy private practice with plenty of "back" patients. Without getting even more specific than "low back pain," but with the proviso that "other problems" be absent, she drew up an admirable set of guidelines to determine which patients would be appropriate for her study. It turned out, however, that she couldn't find more than 2 or 3 patients who would qualify. In the end she had to compromise on the "purity" of the "low back problem" and got the usual muddled results that you might expect from a study on 10 or 20 patients with "low back pain." So the importance of highly disciplined multicenter studies on a large number of patients becomes clearer, but even those studies have a problem in that the clinician loses flexibility in spontaneously modifying treatment as things progress. Thus we PTs end up having to plod along with fuzzy knowledge just like everyone else. Not that we should give up on our efforts, but at least we need to confront such practicalities when we head into studies, or even when we discuss them.

Sincerely,
Paul Andrew
Hiroshima, Japan

To the Editor:

Rennie Maeda's recent attempt (Letter to the Editor *Orthopaedic Practice* Vol. 11;4:99) to sort out the differences between medical diagnosis and physical therapy diagnosis is to be commended, if not for its clarity, at least for its honest tone of frustration with a system of disease classification that has failed both the medical and therapy communities, not to mention our patients.

However, Mr. Maeda complains about an "impairment-based" trend in diagnosis and treatment that leaves me confused. And I mean totally. Mr. Maeda states that to find and treat key impairments is "overly simplistic," and that "these impairments *along with* (emphasis mine) history, signs, symptoms and goals comprise the physical therapy diagnosis." But I cannot for the life of me see a clear distinction between a sign and an impairment, or between history and symptoms. And I never heard of goals contributing to a diagnosis. I have reread this paragraph many times, and it remains as mysterious as ever.

In the next paragraph there seems to be an attempt on Mr. Maeda's part to separate diagnosis into useful and telling categories, although it fails to distinguish between what the physician offers and what the physical therapist might conclude following an independent examination.

Again, I find his description confusing and, in some cases, it reveals the same lack of sophistication regarding low back pain that he decries in the medical community. For instance, his classification of "disc syndrome" as an "extension treatment category" is, to put it kindly, incomplete. And his phrase "McKenzie extension exercises" would make the adherents of that school howl. It is in this section of his letter that he introduces the term "treatment-based diagnosis," although I am not at all certain what this means. Perhaps, as he later (kind of) states we should be crafting our physical therapy diagnosis around which treatments work for various lesions associated with a variety of impairments. Again, this description is very unclear.

Perhaps it would help all of us to remember that there are really just 2 sorts of diagnoses—*essential and nominal*. The former describes the nature of the problem and the tissue involved, the latter simply provides a name for a condition. For example, "humeral fracture" is essential and it implies the treatment necessary. On the other hand, "low back pain" is nominal and does nothing to help us plan our care.

The fact is an accurate and relevant essential diagnosis is often not possible until after some treatment has taken place, and neither the physician nor the physical therapist can always be expected to possess all the tools necessary to come up with it. Until then, a nominal diagnosis will have to do. It is everyone's job to discover the lesion in the proper tissue, and impairments often lead us to do so. (For a further description of diagnostic categories see *Fibrositis: Does it exist and can it be treated?* by Robert Sennett in the *Journal of Musculoskeletal Medicine* June 1984, pg. 72, or *What's in a Name?* and *Incantation* by Barrett L. Dorko, PT copies available from the author.)

Mr. Maeda's frustration and passion for change are certainly evident in his writing. But if there is a solution to the problem of diagnosis here, I cannot see it.

Barrett L. Dorko, PT

Response by Rennie Maeda, PT

I would like to thank Paul Andrew and Barrett L. Dorko for taking the time to read and respond to my Letter to the Editor. I also congratulate the Editor for allowing a forum for discussion of physical therapy issues. I hope that you will continue to do this in the future.

This letter was written simply to stimulate discussion on what constitutes a physical therapy diagnosis.

Andrew's comments on the difficulties he has witnessed in trying to do research on a more homogeneous patient population are well appreciated.

I have been attempting to categorize my patients into discrete classes for many years now and am unable to much of the time. Multiple diagnosis is the rule with patients with low back pain. Any diagnostic system must deal with this. One thing to remember is that a diagnostic system should not be a static one. Modification or updating of a system is essential.

Dorko is very astute in recognizing my frustration with current methods of movement disorder diagnosis. I hope that the following will answer some of the questions brought up by Dorko and perhaps are in the mind of other physical therapists as well. I hope also that

it raises some questions.

First, let me explain what I mean by a trend towards an "impairment-based" diagnosis. In 1997, the following was given as part of a presentation entitled "Physical Therapy Diagnosis and Management of Lower Quarter Disorders" at the Annual Conference of the California Chapter of the APTA (CCAPTA).

> "Physical Therapy Diagnosis
> A summary of the *key impairments* (italics mine) as related to the patients disability and handicaps"
>
> "Sample PT diagnoses: Knee mobility deficits (restricted patella medial glide); coordination deficit (unable to single leg stand > 30 sec.); lower extremity strength deficit (gluteus medius 3/5, fatigue @ 8 repetitions of contralateral pelvic elevation); and skeletal malalignment, (Q-angle 18 degrees). These impairments result in reduced capacity to climb stairs and walk on changing or uneven terrain (tolerates <1 flight, 2 minutes on uneven terrain."

In 1999, the monthly newsletter of the CCAPTA[7] states:

> "The first phase is the screening of red flags that might suggest that the problem presented is outside the scope of practice of a physical therapist and must be referred on to a medical provider. This aspect of diagnosis is called medical screening.
>
> The second phase of diagnosis by a physical therapist is drawing conclusions from the examinations that are *impairment/disability driven* (italics mine) and which form the basis of the diagnosis made by the physical therapist."

Because of these statements and conversations with other physical therapists in California, I take this to mean that the CCAPTA is saying that physical therapy diagnosis is or should be a list of *key impairments* and how they relate to disabilities and handicaps. Perhaps I am oversimplifying the CCAPTA's position.

My point is that as a physical therapist I am able to make other types of diagnoses based on other factors *in addition to* key impairments. I believe we can make soft tissue as well as movement diagnoses. Other factors include, but are not limited to:

- the patient's surgical history (eg, patellofemoral dysfunction s/p ACL reconstruction with autologous graft or s/p total knee arthroplasty),
- the treatments that will likely make the patient better (eg, extension-mobilization category [see below]),
- the tissue diagnosis (eg, biceps strain or patellofemoral joint dysfunction),
- symptoms (eg, low back pain), and
- function (gait disorder).

I do agree with Dorko's statement that it is "everyone's job to discover the lesion in the proper tissue, and impairments often lead us to do so."

As for a "solution," I do not presume to have one. I have previously published a paper on a diagnostic and statistical manual for physical diagnosis.[5] In it I describe a multiaxial nosology and discuss the many ways in which it would be of benefit to our profession. I suggest this paper as a "talk point" for discussion on physical therapy diagnosis. Utilizing this multiaxial schema for diagnosis for the impairment-based physical therapy diagnosis listed above, I would diagnosis this as:

> **Axis I:** patellofemoral dysfunction secondary to direct trauma or secondary to overuse, as the case may be (the physical therapy diagnosis category or the disorder causing the patient's present symptoms).
>
> **Axis II:** restricted patellar glide, coordination deficit, gluteus medius weakness, increased Q angle, or any other functional or biomechanical conditions that may be useful in understanding or managing the disorder.
>
> **Axis III:** any medical or psychological diagnosis or factors that affect recovery from the Axis I disorder (eg, a recent myocardial infarction limiting the ability to participate in an exercise program, a medical diagnosis of patellofemoral osteoarthritis confirmed on X-ray , or an obssessive-compulsive disorder that prevents the patient from being at his physical therapy appointments on time).
>
> **Axis IV:** functional rating—reduced capacity to climb stairs and walk on changing or uneven terrain (tolerates less than 1 flight of stairs or 2 minutes on uneven terrain).

I do believe that when appropriate, physical therapists should be able to make the diagnosis that includes the above axes. Of course, a diagnosis assumes a *pre-existing series of categories or classes* to provide the framework for the diagnosis. What I propose is that we continue a dialogue on physical therapy diagnosis and that the APTA assist in this matter.

A list of a patient's impairments does not lend itself to further research by giving more homogeneous populations to better show a treatment affect. A list of impairments does not give a complete picture of how to treat a patient (many patients can have the same list of impairments and disabilities, but have differing tissue diagnosis or surgical history that require different treatment approaches with differing prognoses). A list of impairments does not truly constitute a diagnosis. A list of impairments when grouped into diagnostic categories or syndromes does constitute a diagnosis.

I must also say, that in many ways I prefer to call a physical therapy diagnosis either a physical or a movement disorder diagnosis (a mouthful)—one that can also be made by a physiatrist, other physician, or other health care practitioner who has been trained in the diagnosis of physical disorders. This type of paradigm, where a diagnostic classification system is not limited to use by a particular type of health care provider, is not unlike that found in the Diagnostic and Statistical Manual of Mental Disorder (DSM-IV).[1] The DSM-IV is meant to be utilized by "psychiatrists, other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, counselors, and other health and mental health professionals."

Dorko may be correct in his characterization of my lumbar diagnoses as unsophisticated and incomplete, but I have heard countless physical therapists, OCSs, teachers, and others, speak of treating "discy symptoms" with "McKenzie extension" exercises. The list was not meant to be complete. This points to the confusion amongst groups of differently-trained physical therapists

and the need for a more widely accepted language.

A *treatment-based classification approach* has been discussed in our own journal. Delitto, Cibulka, Erhard, et al[3] concluded that "a priori classification of selected patients with low back syndrome into a *treatment category* (italics my own) of extension and mobilization and subsequently treating the patients accordingly with specified interventions can be an effective approach to conservative management of selected patients." Delitto, Erhard, and Bowling[4] again presented a *treatment-based* classification system for low back syndrome in 1995. In addition to these *Physical Therapy* articles, I would also like to recommend a report on a survey of physical therapy experts on the diagnostic classification of patients with low back pain by Binkley et al[2] and an excellent article by Riddle[6] which critically reviews several classification systems for patients with low back pain. There are many other interesting articles by physical therapists and others concerning diagnostic categories. Perhaps in addition to the Evidence Express in *Orthopaedic Physical Therapy Practice* 1999;11(1), there can be a Diagnosis Express.

I hope this clears up any confusion. I continue to welcome dialogue on the subject. And as for one last bit of confusion, I am a male.

1. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, ed 4.* Washington, DC:American Psychiatric Association, 1994.
2. Binkley J, Finch E, Hall J, et al. Diagnostic classification of patients with low back pain: report on a survey of physical therapy experts. *Phys Ther.* 1993;73:138-155.
3. Delitto A, Cibulka MT, Erhard RE, et al. Evidence for use of an extension-mobilization category in acute low back syndrome: a prescriptive validation pilot study. *Phys Ther.* 1993;73:216-228.
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■

Practice Affairs Corner
Defend Skilled PT Practice Scope or Perish: A Need to Take A Stand
A personal opinion revisited

Stephen McDavitt, PT, MS

In *Orthopaedic Physical Therapy Practice* (Vol. 11:1:99) I wrote a letter to the editor entitled Defend Skilled PT Practice Scope or Perish: A Need To Take A Stand. The letter focused on the philosophy that it is time we take a stand on teaching manipulation and manual therapy procedures to support personnel including physical therapist assistants. Even though the descriptions of practice standards in the *Guide to Physical Therapist Practice*, position statements from the American Academy of Orthopaedic Manual Physical Therapy (AAOMPT) and Orthopaedic Section of the APTA, and those standards described in the Description of Advanced Clinical Practice (DACP) from the AAOMPT do not support the teaching or practice of manipulation or mobilization by physical therapist assistants, this continues to be an unresolved issue in the practice of physical therapy today.

It is time we begin to resolve practice issues of skilled vs. supportive practice scopes and related practice affairs especially as they apply to manipulation/mobilization in this upcoming APTA House of Delegates 2000.

I recently received a copy of the most recent APTA Board of Director's minutes dated November 13-15, 1999 and I would like to share some of that relevant information. This information directly addresses this issue of education of supportive personnel as it relates to delegation and separation of skilled and nonskilled practice and remuneration. I am going to provide the information along with the support statements for 5 different motions.

Board of Director's Minutes dated November 13-15, 1999

V-80: PASSED (work group 3).
That the following motion be presented to the 2000 House of Delegates:
That the following position be adapted: Position on Direct Interventions Exclusively Performed by Physical Therapists. The physical therapist's scope of practice as defined by the Guide to Physical Therapist Practice includes all interventions performed by physical therapists. These interventions include procedures performed exclusively by physical therapists and selected procedures that can be performed by the physical therapist assistant under the direction and supervision of the physical therapist. Direct interventions within the scope of the physical therapist practice that are performed exclusively by the physical therapist include, but are not limited to, spinal and peripheral joint mobilization/manipulation, which are components of manual therapy techniques, and selective sharp debridement, which is a component of wound management.

SS: The Association should not delineate those interventions which, due to their clinical complexity and the sophistication of judgment required to perform them, precludes delegation to paraprofessionals or others. This position is consistent with the House of Delegates endorsed *Guide to Physical Therapist Practice* and the Normative Model of Physical Therapist's Education.

V-55: PASSED (work group 2).
That the Normative Model of Physical Therapist's Professional Education, version 2000, be consistent with the Guide to Physical Therapist Practice.

SS: All APTA documents should be consistent with manipulation (grades 1-5) as defined by the *Guide to Physical Therapist Practice*, revised edition, July 1999 (program 19, exhibit U, BOD 11/99).

V-56 PASSED (work group 2)
The APTA undertake efforts to encourage the State Boards/Regulatory agencies to utilize part I of the Guide to Physical Therapist Practice as a reference for issues related to the scope of practice.

SS: Having State Boards/Regulatory Agencies familiar with the *Guide* helps the profession successfully protect manual issues including manipulation. APTA will distribute the *Guide* to State Boards/Regulatory Agencies as a reference work.

V-65 PASSED (work group 2)
That all APTA sponsored educational programs be reviewed for consistency with the Guide to Physical Therapist Practice.

SS: APTA has distributed copies of the *Guide to Physical Therapist Practice* to third party payors. APTA holds the *Guide* as being the template or benchmark against which physical therapist practice is measured. By requiring educational program consistency with the *Guide*, the Association will further emphasize the importance of the *Guide* to help practitioners justify reimbursement for physical therapy services. This supports goal 1, objective 1, of the strategic plan for reimbursement (program 37, exhibit 26, B-D 11/99).

V-64 PASSED (work group 2)
That APTA pursue incorporation of the services provided by physical therapist assistants into the practice expense component of the resource base relative value scale (RBRVS) payment methodology, with associated review and recommendation for modification to relative value for work of the physical medicine and rehabilitation family of codes.

SS: The Advisory Panel on Reimbursement recommends that the Board of Directors not remain silent on the issue of potential different valuing of physical therapist assistant's services. Physical therapist assistants do not provide physical therapy services but rather assist in the provision of physical therapy services. Physical therapist assistants therefore must be supervised by a physical therapist and should then be considered part of the practice expense component of RBRVS. By incorporating physical therapist assistant's services into the practice expense component, APTA can develop strategies to re-evalu-

ate the relative value of the work expense component in relation to time, physical effort, mental effort/judgment and provide a risk.

I believe it was said best under VD-64. *"Physical therapist assistants do not provide physical therapy services but rather assist in the provision of physical therapy services."* In addition to this, the *Guide to Physical Therapist Practice* clearly explains that manipulation and mobilization are skilled components of physical therapy services. They are clearly outside the scope of the physical therapist assistant. That concept was clearly supported in the proposed RC-35 presented to the House of Delegates in 1999 (cosponsored by the Orthopaedic Section and APTA BOD) and then endorsed by the Board of Directors (V-80) to be provided as an RC before the House of Delegates in 2000.

Another consideration along these lines is that if we are looking at physical therapist assistant's services in the practice expense component in treatment, then the RBRVS value could be further diluted by providing the physical therapist assistant with the ability to provide manual manipulative therapy at a less "skilled" level. Where do we carve that out in practice standards?

We also must consider the signal that we are giving the physical therapist assistant. It is disillusioning to them to be allowed to take certain manual manipulative therapy courses and not others or not actually practice what they learn. Beyond inappropriate, any physical therapist with the philosophy of delegating those services is also unfair to the PTA's vision of their future in the practice of physical therapy. Consider also potential impacts on legislation and public safety.

It is time that we begin to draw the line in the sand separating out those services that are supportive in providing physical therapy services and those which are skilled and need to be practiced exclusively by the physical therapist.

The *Guide to Physical Therapist Practice* defines manipulation and mobilization as:

Manipulation: A skilled passive hand movement that usually is performed with a small amplitude at a high velocity.

Manual therapy techniques: A broad group of skilled hand movements, including but not limited to *mobilization* and *manipulation*, used by the physical therapist to mobilize or manipulate soft tissues and joints for the purpose of modulating pain; increasing range of motion; reducing or eliminating soft tissue swelling, inflammation, or restriction; inducing relaxation; improving contractile and noncontractile tissue extensibility; and improving pulmonary function.

Mobilization: A skilled passive hand movement that can be performed with variable amplitudes at variable speeds. *Manipulation* is one type of mobilization.

The AAOMPT Description of Advanced Clinical Practice further defines manipulation/mobilization as "the skilled passive movement to a joint and/or the related soft tissues at varying speeds and amplitudes including a small amplitude, high velocity therapeutic movement."

The psychomotor (demonstration) component of manipulation/mobilization may be realistic to teach a PTA. The cognitive and affective learning domains that provide the skilled clinician with the ability to diagnose and manage the clinical decisions in practice of manipulation however require a physical therapists' knowledge base. Considering what has been presented by the APTA Board of Directors, promoted by the Orthopaedic Section BOD, and clearly from what is represented in the *Guide to Physical Therapist Practice*, physical therapist assistants should not be allowed to practice manual manipulative therapy or take manual manipulative courses. If PTAs want such skills, I recommend they consider physical therapy education and competency.

From what I have described above, I don't see anything that supports even remotely the concept that we should be supporting physical therapist assistants practicing or being educated in manual mobilization/manipulative techniques. *Delegating out such skilled services to supportive personnel in my opinion is as detrimental to physical therapy as is giving up components of physical therapy scope of practice in legislative compromise to achieve direct access.* The impact and risk of further blemishing our skilled competencies in the eyes of an already contentious legislative climate is also a necessary consideration.

All of this may seem small now, but on the long scale multiplied over the number of years, it will be devastating to our scope of practice and remuneration for our skilled practice as physical therapists. Just ask those states involved in defending *22 pieces of legislation* last year directed at *contesting the physical therapists' competency* in providing manipulation and mobilization manual therapy techniques.

As these skilled practice issues mentioned here develop into debates throughout the component caucuses and House of Delegates 2000, I hope my personal opinion and discussion here will facilitate constructive dialogue, support, and resolution for those related positions presented from the APTA Board of Directors, the Orthopaedic Section, and the AAOMPT.

I believe physical therapists need to act and take a formal stand NOW. Our scope of practice, remuneration, and professional survival are dependent on our position. We need to defend skilled physical therapy practice by "drawing the line in the sand" separating skilled from supportive scope in practice, or perish. ■

New McKenzie Online Study Group

There is a new online study group whose mission is to study the "Mechanical Diagnosis and Treatment" methods of McKenzie. We discuss the McKenzie method, review research related to the spine, and present case studies for the input and help of our members. All are welcome, and it is free to join. Simply go to www.McKenzieStudy.listbot.com to review the archive of emails and subscribe or send an email to: McKenzieStudy-subscribe@listbot.com. If you have any questions or require help at any time, please contact Heather Murray-Miller, PT at murmil@aol.com.

Book Reviews

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

Lee PA, ed. *Casting Protocols for the Upper and Lower Extremities.* Gaitersburg, MD: Aspen Publishers; 1999:205 pp.

Casting Protocols for the Upper and Lower Extremities is an excellent procedural manual for the clinician. The contributor list is multidisciplinary comprised of occupational therapists, physical therapists, and physicians from the Rehabilitation Institute of Chicago. The manual emphasizes the theoretical framework for and the practical application of various types of casting. Along with specific casting techniques, the authors also emphasize the importance of goal setting and outcomes assessment.

The book is divided into 11 chapters. The first chapter provides a combination of well-referenced clinical and basic science rationale for the use of cast management for peripheral joint contractures and muscle hypertonicity. The second chapter lists in detail precautions to consider in casting, as well as the level of competency needed to perform casting skills.

Chapters 3 through 5 include descriptions of upper extremity motor disorders, assessment, and appropriate types and application of casts. Included are drop out, long arm, and circular casts with variations for including or excluding the wrist and fingers. The casting procedures and materials needed are described for joint contractures along with problems of abnormal muscle tone and movement disorders of the upper extremity. The chapter on assessment recommends the use of objective and functional measures in determining the success of the procedure. Chapters 6 and 7 then provide similar detail for lower extremity casting including short leg, serial knee, tone reducing footplate, and supramalleolar orthosis casting.

The remaining chapters are divided into cast removal and bivalving, considerations for specific diagnoses, medical management of spasticity, and upper extremity surgery. The information on cast removal and bivalving includes specific procedures and equipment needs. The chapter on considerations for specific diagnoses presents excellent case studies related to patients diagnosed with spinal cord injury, cerebral palsy, brain injury, burns, and juvenile rheumatoid arthritis. The final 2 chapters on medical management of spasticity and upper extremity surgery, although interesting and well presented, seems superfluous to the stated purpose of the text which is cast management of upper and lower extremity contractures and hypertonicity.

This manual is highly recommended as a reference for facilities already involved in or considering becoming involved in cast treatment and management. Faculty involved in teaching cast management principles and application also would find this text to be an asset. The detailed information, excellent use of photographs and emphasis on safety and assessment make this a valuable asset to both the experienced and novice clinician.

Patricia Downey, PT, MS, OCS

Hagen C. *Rehabilitation in Managed Care. Controlling Cost, Ensuring Quality.* Gaithersburg, MD:Aspen Publishers; 1999:323 pp.

Are cost shifting, Indemnity Insurance, PPO, HMO, DRGs, PPS, Medicare PPS, RUGS, TEFRA, RBRUS, Physician Fee Schedule, and Balanced Budget Act words and acronyms you hear frequently? *Rehabilitation in Managed Care* provides an excellent reference to understand the lexicon of today's HMO environment. The purpose of this book is to provide therapists and managers the tools to move from the historical role of the therapist as a provider to today's multifaceted role: providing excellent clinical outcomes and sharing fiduciary responsibility.

This book is essential for all therapists. The ideas of evaluation and treatment should be reconsidered to evaluation and *management* in our current health care environment. Profitability is reported to be through cost management, and the therapist plays a pivotal role in this endeavor. With reimbursement either decreased or capitated, and salaries contributing to 50% to 60% of the operating budget, clinical decisions hold the potential to maintain therapy jobs. *Rehabilitation in Managed Care* offers suggestions for therapists to manage cost (and jobs) by using clinical case management tools, managing therapy resources, treatment duration, service delivery format, level of care, and risks of complications. Another chapter is devoted to successful documentation. Documentation is essential not only to ensure quality of patient care, but also to negotiate fair reimbursement.

The text also is relevant to administration. It is one of the first texts to elaborate on the continuum of care in rehabilitation. Rehabilitation patients, with good clinical care management, may move through different levels of care with quality and decreased costs. Other tools are discussed for case management, family management, and team management.

With health care changing quickly (the text was printed before the moratorium on the $1,500 reimbursement cap), this book is essential for cost containment. The information will help therapists become partners with administration to assist with major decisions in the clinic. I highly recommend this text to all therapists, administrators, and teachers in the health care arena.

Daryl Lawson, MPT

Pope T, Loehr S. *Atlas of Musculoskeletal Imaging.* Thieme, NY: 2000:532 pp.

This atlas illustrates 355 magnetic resonance (MR) images that display the normal anatomy of the upper and lower extremities as well as the lumbar spine. Each of the 8 chapters is organized in the same fashion. The authors provide a brief introduction including indications for MR imaging and the most common pathologic processes in the region. Next are sections on protocol suggestions and a menu of protocols. This is followed by a listing of major osteochondral structures and landmarks, major ligaments, tendons, and bursae and the origin, insertion, and innervation of the major muscles specific to the region being imaged.

The images in the text are clear and well marked. The pictures are enlarged enough to be viewed easily by the reader but the acuity is not sacrificed. As this text's goal is to assist the clinician in interpreting MR imaging, both the right and left extremities are illustrated for comparison. The entire length of each extremity has been imaged to illustrate the anatomy between the joints.

While the book is very comprehensive, it would have been more complete with imaging of the cervical and thoracic spines. There was no mention of why these regions were omitted. I would hope that the authors would include images for commonly viewed pathology for each region.

The value of this book is mainly for the radiologists interpreting these studies as well as to any provider that refers patients for MR imaging. However, I have also found it useful for patient education. The common saying of "a picture is worth a thousand words" holds true when one is attempting to describe to a patient the appearance and location of orthopaedic pathology.

Jeff Yaver, PT

Software Review

Wiksten D, Barry B. *Upper Extremity Injury Evaluation: An Interactive Approach*. Epler M, Wainwright S. *Manual Muscle Testing: An Interactive Tutorial.* Van Ost L. *Goniometry: An Interactive Tutorial.* Thorofare, NJ: Slack Incorporated; 2000.

This review will examine the 3 software programs listed. System requirements for each program are listed below. In general, installation of each of these programs is quick and easy, and navigation through the programs is simple. The key feature for each of the programs is that the user can review the material through video, audio, and written instructions.

Upper Extremity Injury Evaluation: An Interactive Approach is a software package that presents pertinent orthopaedic special tests in the following areas: cervical spine, brachial plexus, shoulder, elbow, and wrist and hand. For example, at the shoulder, actual examiners demonstrate the following special tests: acromioclavicular joint stress test, Yergason's test, empty can test, sulcus sign, anterior drawer test, anterior and posterior apprehension tests, and impingement test. Each special test module for the particular body area has a clear and concise video and audio demonstration that discusses the appropriate position for the examiner and the subject, the examination procedure, the implications and pathomechanics of a positive test, and negative test results. Also, a 3-dimensional anatomy tour reviews the structures specific to each special test. An interesting and valuable feature of the program is an animated replication of positive test results as they pertain to specific injuries and affected structures. (System Requirements for a PC include: Pentium 100 or faster processor, Microsoft Windows 95 or Windows NT 4.0 or later, 2X CD-ROM drive, 16 MB of RAM, 1 MB SVGA video card, 8-bit Sound Blaster-compatible sound card. And for the Macintosh: Power PC processor, Mac OS version 7.5 or later, 2X CD-ROM drive, 16 MB of RAM).

Manual Muscle Testing: An Interactive Tutorial and *Goniometry: An Interactive Tutorial* are software packages that present manual muscle testing and goniometry techniques, respectively. Each program contains 3 sections: Basics, Body Regions, and a Self-Assessment Quiz. While the "Basics" section of *Manual Muscle Testing* covers issues of reliability, the sequence of strength assessment, grading strength, and factors affecting muscle strength, the "Body Regions" section allows the user to access multiple methods of manual muscle testing for the upper body, lower body, and trunk. For each manual muscle test, dynamic and break testing instructions are available, as well as comprehensive coverage of other testing elements including appropriate positioning, stabilization, palpation, and possible substitution patterns that may be evident during testing. Muscle testing positions demonstrate subjects working against gravity and in gravity-minimized positions. While the "Basics" section of *Goniometry* covers issues like terminology, fundamental concepts, and proper notation, the "Body Regions" section allows the user to study goniometric techniques for the temporomandibular joint, upper body, lower body, and trunk. For each goniometric technique, the starting and ending point for the measurements are covered, as well as appropriate testing positions, goniometric alignment, and possible substitution patterns that subjects may exhibit. Furthermore, the suggested range of motion, end-feel, and capsular pattern are described for each joint. The scope of content coverage in both of these programs is similar to classic texts. However, unlike a textbook, each program is comprised of a clear video that demonstrates techniques, and a concise narration and text that explain the elements of each test. A self-assessment quiz is also available on each program. (System Requirements for *Manual Muscle Testing* and *Goniometry* for a PC: Pentium-based PC or above, Windows 95 or later, 16 MB of RAM, 15 MB of hard disk storage, 1 MB SVGA video card, 8-bit Sound Blaster-compatible sound card; for the Macintosh: Power PC or above, 16 MB of RAM, 15 MB of hard disk storage, Mac OS version 7.1.2 or later.)

A significant benefit of this package of programs is the step-by-step format used, allowing the user to view the material at his/her own pace. Furthermore, the variety of instruction methods utilized (ie, video, audio, text) makes these programs useful for individuals with different learning preferences. Because of the comprehensive nature and clear instruction provided by these software packages, they are highly recommended for physical therapists or physical therapy students that need to learn or review upper extremity orthopaedic special tests, manual muscle testing, and goniometry. Orthopaedic physical therapists that have significant experience may not benefit as much from these programs. For entry-level physical therapy programs, these software packages would serve as an excellent addition to traditional methods of instruction.

Michael Ross, Capt., USAF, BSC

2000 Rose Excellence in Research Award Acceptance Speech

Mark Werneke MSPT, DipMDT

INTRODUCTION

Understanding the significance of this recognition and knowing who the past recipients were, I humbly and with great gratitude accept this award. I would like to thank the research committee for considering our paper; and this was an "OUR" paper. This study was possible because of the tremendous support and efforts by my co-authors Dr. Dennis Hart and David Cook. I also would like to thank the physical therapists who worked with me in the clinic collecting the research data over a 2 year period including: Charles Moulton, Mary Beth Behringer, Patrick Duffy, and Paul Weiss.

I was asked to speak on how our paper might affect the orthopedic physical therapy profession. This is certainly a challenging topic, but I will give you my best answer from a clinician's perspective.

My comments today will be confined to those related to patients with an acute onset of nonspecific low back pain (LBP) syndromes. This patient population has been of particular interest to me over the past 10 years. A persistent question about treating these patients has been on my mind for a long time: do physical therapists have a place in treating patients with an acute onset of pain or are we placebotists entertaining our patients while natural history affects a cure? Perhaps patients with an acute onset of pain may be best left untampered with. This question motivated me to scour the literature, to understand it, and finally to challenge the literature based on my daily clinical experiences and observations as a physical therapist.

The 1990s has truly been the golden era for primary care research on patients with low back pain. Yet, the *attention getting* headlines from the international research community, at least from my perspective as a physical therapist, have not been that encouraging. For example:

- our physical measurements and treatments are ineffective and do not influence outcomes!
- exercise for patients with acute LBP? Nonsense - exercise makes no difference, in fact it can make the patient worse and dependent on the health care system!
- the best treatment is no treatment at all— outside of the physician's advise to take medications and to go home and walk and don't worry about it!

These messages were pretty upsetting for me, considering I devoted a large part of my career and educational pursuits to evaluating and treating patients with spinal troubles. When all of these research headlines started to appear in the mid 1990s, I had just finished the diploma program from the McKenzie International Institute and felt confident in my ability to evaluate and treat this particular group of patients. Many patient's responded immediately to exercise and movement strategies and to my educational efforts. Why were my clinical observations and outcomes so different from today's evidenced-based medicine for managing the patient with acute LBP?

> It is my belief that our clinical experiences are very important and yet, we need to validate these experiences with experimentally designed qualitative or observational studies which can lead to better randomized controlled treatment trials.

It is my belief that our clinical experiences are very important and yet, we need to validate these experiences with experimentally designed qualitative or observational studies which can lead to better randomized controlled treatment trials. We also need to critically analyze the literature. We cannot just read the author's summary, conclusions, and abstract for our information, but we need to take an in-depth look at the study's methodology and data analysis. This will allow us to ask better research questions to ensure that the independent variable in question is adequately investigated whether it be exercise, provider type, education, etc.

Obviously to challenge the literature you need to understand it first, for example, what does present evidence-based medicine say about acute low back pain and nonspecific low back pain?

ACUTE LOW BACK PAIN

Present clinical teachings are that 90% of patients with an acute episode of LBP recover within 4 weeks. Frank has referred to this period of time as stage 1 because the natural history for spontaneous recovery is thought to flatten out after this time frame. Because of this assumption, many authors say the best treatment is no treatment, with the idea being to not over-medicalize the problem nor to interfere with natural history!

I believe the concept of 90% of people with low back injury recover within the first month is a limited view. Only 38% of the patients in our study, after an acute onset of LBP, were painfree at 1 year, and 28% reported prolonged activity interference at home at 1 year. These findings are similar to recent results published by Cherkin and Von Korff.

We also know that acute pain can not be isolated to a single event. An acute episode must be viewed within the perspective of the patient's past medical history concerning previous LBP troubles and with the anticipation that LBP is recurrent with another 1 to 2 episodes in the follow-up year. In addition, adults who seek care during an acute episode of pain and self-refer to a doctor are not the same, and are probably more complex, than similar adults with an acute episode of LBP who do not seek care.

Considering the complex biopsychosocial factors as to why an adult chooses to become a patient, as well as the con-

cept that back pain is a continuum over one's lifetime, the clinician should not dismiss the resolution of the acute episode so readily to natural history. But at minimum, the treatment for a care seeker requires reassurance and education on problem solving techniques for self-care. For certain subgroups of patients with an initial episode of LBP, the pain is recurrent, does not necessarily resolve quickly, and can predict future disability episodes. With early and comprehensive evaluations of patients with an acute onset of nonspecific low back pain syndromes from a biopsychosocial perspective, physical therapists will obtain valuable insights into: (1) understanding why natural history is so fragmentary or variable among different patients, (2) identifying early on those patients at risk for delayed recovery, and (3) developing minimal yet progressive treatment strategies with the specific goal to prevent chronic disability.

NONSPECIFIC LOW BACK PAIN

Another concept which needs review is the term nonspecific LBP. The term nonspecific is very useful for diagnostic triage: separating patients with serious spinal pathology and those patients with persistent and progressive neurological deficits from patients with nonspecific LBP syndromes is important. However, once diagnostic triage is completed, this nonspecific term is like a black box for the clinician. It is no longer useful in guiding our every day clinical decisions. Nor is it useful in interpreting outcomes in the literature comparing different treatment strategies for such a large heterogeneous group of patients. It is obvious not every patient with nonspecific pain is the same: some require just reassurance, some need more complex problem solving techniques to improve coping strategies as function is restored, and others quickly benefit from mechanical movements and positions.

If research is going to yield worthwhile clinical information then patients with nonspecific LBP need to be classified into meaningful subgroups. If this can be done, we can compare results between studies more effectively (ie, comparing apples to apples, oranges to oranges, etc.). The 2nd International Forum on Primary Care Research on LBP strongly stated that subclassification of patients needs top research prioritization. If you think about it, the research community has handed physical therapists a gift. A gift in the sense that research considers over 90% of patients with LBP to have nonspecific pain, and nonspecific pain has been defined in the literature as mechanical pain because it is affected by physical movements and activities. Therefore, as physical therapists we can play a significant role in classifying patients by utilizing our skills in movement analysis. Such movement diagnoses can differentiate mechanical from nonmechanical patient responders.

I feel our research studies are an example of the ability of physical therapists to reliably subclassify patients with an acute onset of pain into meaningful subgroups by movement signs and symptoms. Classification should guide treatment strategy and have prognostic value, such that the classification allows the clinician to choose the treatment approach. This will result in the desired level of impact on the patient's pain and function. For example, the centralization pain pattern guides the clinician in the selection of mechanical forces based on directional preference, and if this is done, good outcomes will be achieved. If a centralization pattern is not observed, the clinician needs to develop alternative (perhaps nonmechanical) treatment or behavioral and cognitive management strategies for that patient. Once a noncentralization pain pattern becomes clearly established, clinical outcomes will be poor and it is doubtful that continued treatment from a single approach will be effective for that patient with an acute onset of back pain. It was hypothesized in our paper that patients classified into the noncentralization category were at higher risk for developing chronic disability. This hypothesis has been confirmed by our follow-up and long-term research efforts.

SUMMARY

To summarize my thoughts today, we can not isolate our practice to clinical empiricism and anecdotal evidence. As clinicians we need to take a critical look at the scientific data supporting our treatment decisions; however, we cannot blindly follow the present literature as the gold standard to the truth. Our clinical observations are important. If our profession is to grow and thrive into the new millennium, we are obligated to take an active part in research and outcome assessment. If we do not, the clinical experts outside of the physical therapy profession will eventually define, and perhaps limit, our roll in areas in which we have extensive expertise. Our paper is just one small example of communicating such clinical expertise in a scientific format. Our paper clearly shows that physical therapists have an important role in evaluating, classifying, and treating patients with an acute onset of nonspecific musculoskeletal spinal syndromes. ■

2000 CSM Awardees and Student Guest Winner

Rose Excellence in Research Award

Mark Werneke, PT, MS, Dip MDT

Mark Werneke, PT, MS, Dip MDT is the recipient of the Rose Excellence in Research Award for his paper entitled, "A Descriptive Study of the Centralization Phenomenon: A Prospective Analysis," published in Spine 24, 676-683, 1999. The co-authors for this article are Dennis Hart, PT, PhD and David Cook, BS, RN.

Mr. Werneke received his master's degree in Physical Therapy from Boston University in 1979 and is currently a full-time clinician and Center Manager for Nova Care in Forked River, New Jersey. He has studied orthopaedic manual therapy extensively and passed the credentialing examination in McKenzie Mechanical Treatment in 1993. He received his Diploma from the McKenzie International Institute in 1995. He has published previous work in Spine and the McKenzie Institute Journal and continues to be active in clinical research. He also has lectured extensively on topics related to low back pain. Congratulations to Mark and his coauthors on this excellent work!

Paris Distinguished Service Award

Robert E. Burles, PT

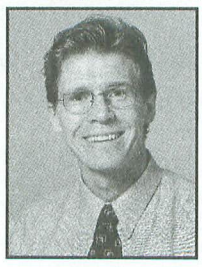
The Orthopaedic Section is honored to present the 2000 Paris Distinguished Service Award to the family of Robert E. Burles in memory of Bob's tremendous service to the Orthopaedic Section and to the physical therapy profession.

During Bob's long and distinguished career, he was active both locally and nationally. Bob's most obvious contribution to the Orthopaedic Section was through his service as Chair of the Finance Committee for 8 years and as Treasurer for 5 years. Notwithstanding this valuable commitment, Bob is best known by Section members for his enduring contribution to the modernization and computerization of the Section office. His role in setting up our computerized database system set the stage for the system that we have today and allowed us to expand our services to members, communicate more efficiently, and reach a broader audience. This technology has been a key to the continued growth and success of the Orthopaedic Section.

Bob was unselfish in his efforts to improve the practice of physical therapy in his home state of Oregon. He was President of the Oregon Chapter of APTA. For years, he served as liaison to the Oregon Worker's Compensation Division and was instrumental in rewriting the worker's compensation regulations for physical therapy, which have been used as examples throughout the country. Bob was a skilled clinician who showed great empathy and understanding toward his patients. He was one of the founders of the Orthopaedic Study Group in Oregon. He sponsored as well as taught many orthopaedic continuing education courses. He gave freely of his time and knowledge to teaching physical therapy students, both in his clinic and at the School of Physical Therapy at Pacific University.

Bob and his wife, Marion, were married in 1966 and raised 3 children: Cathy, Michael, and Mark. His tremendous devotion to his family was evident throughout his life. Bob passed away on October 25, 1998 as a result of a brain tumor. As the Orthopaedic Section remembers Bob's tremendous service to our profession, we realize how fortunate we were to have had Bob as our friend and colleague.

Award for Excellence in Teaching Orthopaedic Physical Therapy



Guy Simoneau, PT, PhD, ATC

Guy Simoneau, PT, PhD, ATC is the recipient of the Orthopaedic Section's Award for Excellence in Teaching Orthopaedic Physical Therapy. Dr. Simoneau is an Associate Professor in the Department of Physical Therapy at Marquette University where he is highly regarded as a scholar, researcher, clinician, and teacher. He is a recent recipient of APTA's Margaret L. Moore Outstanding New Academic Faculty Award and the Sports Section's Education Award. His colleagues and students at Marquette University credit Dr. Simoneau for transforming its orthopaedic curriculum in 6 short years into a series of courses which is widely viewed, both locally and nationally, as the strength of Marquette's physical therapy program.

Dr. Simoneau is an Editorial Board Member and Associate Editor for Special Issues and Proceedings for the *Journal of Orthopaedic and Sports Physical Therapy* and a Manuscript Reviewer for *Physical Therapy*. He also enjoys a national reputation as a researcher and was the 1997 recipient of APTA's Eugene Michels New Investigator Award.

Dr. Simoneau's soft-spoken, humble, yet authoritative style is both nonthreatening and motivational to students. He creates the kind of learning atmosphere that his colleagues admire and strive to emulate. He exhibits great enthusiasm, commitment, and pride in his work and for his profession and is an excellent role model for students. Dr. Simoneau is truly a worthy recipient of the Award for Excellence in Teaching Orthopaedic Physical Therapy.

Outstanding Physical Therapy Student

Matthew T. Crill, MS, CSCS

Matthew T. Crill, MS, CSCS is this year's recipient of the Orthopaedic Section's Outstanding Physical Therapy Student. Mr. Crill will be a 2000 graduate of the School of Physical Therapy at Ohio University in Athens, Ohio. For the past 3 years, Mr. Crill has served his class as president and has guided his class through many fund raising and volunteer activities. He has initiated a successful weekly journal club

in orthopaedics and has set an example for his classmates by maintaining memberships in the APTA and the Orthopaedic and Research Sections. He is regarded by his peers and faculty as an excellent student who continually strives for answers to difficult questions in orthopaedic physical therapy.

Mr. Crill has demonstrated a high level of professional responsibility as a student by attending additional continuing education conferences, presenting numerous seminars in muscle biology, and preparing 2 manuscripts for publication. He received an additional Master of Science Degree in Biological Sciences while attending the Physical Therapy Program and has served as a Graduate Teaching Assistant in both anatomy and physiology.

Matt Crill is truly deserving of this award and will certainly be a welcome member of the Orthopaedic Section throughout his career.

Student Guest 2000

Trevor Carlson

This year's winner is Trevor Carlson, CSCS. He is a second year student at the University of Wisconsin at La Crosse. He graduated from Bethel College with a Biology degree and was awarded the Polek Scholarship in his first year at UW. He hopes to pursue his interest in orthopaedic physical therapy after graduation in December 2000. In addition to his course work he and many of his classmates have been very active with Habitat for Humanity.

Trevor attended the Orthopaedic Section Business Meeting, Awards Ceremony, Section programing, and met the Board of Directors and Committee Chairs. By participating he has developed a better understanding of the Orthopaedic Section. This was Trevor's first Combined Sections Meeting, but he assured us it will not be his last. He was very appreciative of the opportunity to attend the meeting and will be a good spokesperson on our behalf.

ORTHOPAEDIC SECTION, APTA, INC.
CSM Board Of Directors' Meeting Minutes

FEBRUARY 4, 2000
NEW ORLEANS, LA

The 2000 CSM Board of Directors Meeting was called to order at the Hilton Riverside Hotel in New Orleans, LA at 8:30 AM on Friday, February 4, 2000 by Bill Boissonnault, President.

ROLL CALL:
Present:
Bill Boissonnault, President
Nancy White, Vice President
Ann Grove, Treasurer
Joe Farrell, Director
Gary Smith, Director
Michael Wooden, Membership Chair
Deborah Lechner, OHSIG President
Lola Rosenbaum, Education Chair
Paul Howard, Education Vice Chair
Carolyn Wadsworth, HSC Editor
Susan Appling, OP Editor
Phil McClure, Research Chair
Steve McDavitt, Practice Co-Chair
Jean Bryan, Specialization and Nominating Chair
Terry Randall, Public Relations Chair
Mary Ann Wilmarth, Incoming Nominating Chair
David Levine, Animal SIG President
Cheryl Riegger Krugh, Animal SIG Education Chair
Bonnie Sussman, OHSIG Vice President

Randy Roesch, APTA Liaison
Terri DeFlorian, Executive Director
Tara Fredrickson, Executive Assistant

Absent: None

MEETING SUMMARY:

The agenda for the CSM Board of Directors meeting on February 4, 2000 was approved as printed.

The minutes from the September 25, 1999 Fall Board of Directors meeting in Alexandria, VA were approved by the Board as printed.

ACTION ITEMS:

=MOTION 1= Approve of the Section paying for NATA CEU certification each year. =PASSED=

=MOTION 2= Amend the 1999 Fall Board of Directors meeting minutes motions 5 and 6 to include the $30 CEU fee as part of the registration fee and not a separate charge. =PASSED=

=MOTION 3= The Fall Board of Directors meeting will alternate every other year between La Crosse and Alexandria. In 2000 the meeting will be held in La Crosse, in 2001 the meeting will be in Alexandria. =PASSED=

=MOTION 4= The Section will reserve a suite in the convention hotel at each CSM and AC. The suite will be used for the Section Board and Executive Committee meetings and be made available to SIGs for their meetings. =PASSED=

=MOTION 5=To rescind the Orthopaedic Section definition on manipulation as presently defined and replace with that described as manipulation/mobilization in the *Guide to Physical Therapist Practice*. =PASSED=

=MOTION 6=The Excellence in Teaching Orthopaedic Physical Therapy Award will be renamed as follows: The James A. Gould Excellence in Teaching Orthopaedic Physical Therapy Award. =PASSED=

=MOTION 7= Approve the following 2001 preconference course for CSM: Pain treatment in the 21st century to include manual therapy, exercise, nutrition, modalities, and complimentary interventions. =PASSED=

=MOTION 8= A task force made up of the following individuals will develop a document on curricular guidelines for orthopaedic residencies that will be made available to Orthopaedic Section members:

1) Kaiser Permanente Southern California, Los Angeles
2) US Army Ortho residency, Brooke Army Medical Center, Fort Sam Houston, TX
3) University of Wisconsin Hospital-Clinics & Meriter Hospitals Orthopedic Physical Therapy Clinical Residency Program, Madison, WI
4) Paul Howard
5) Carol Jo Tichner as Chair possibly

=PASSED=

=MOTION 9= Approve HSC 12.1 for 2002 on *Prosthetics and Orthotics*. =PASSED=

=MOTION 10= Approve HSC 12.2 for 2002 on *Selected Diagnosis in Orthopedics*. =PASSED=

=MOTION 11= The Orthopaedic Section will contribute $50,000 in 2000 and $50,000 in 2001 to the Foundation for Physical Therapy to fund a research study related to the efficacy/effectiveness of physical therapy intervention for orthopaedic conditions. =PASSED=

Adjournment 11:00 PM

ORTHOPAEDIC SECTION, APTA, INC.
CSM 2000 Business Meeting Minutes

NEW ORLEANS, LOUISIANNA
FEBRUARY 5, 2000
HILTON HOTEL: ELMWOOD ROOM
8:30 – 10:30 AM

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

Myrtle Shepard, Registered Parliamentarian, was the parliamentarian for the meeting.

II. BOARD OF DIRECTOR REPORTS

A. President - Bill Boissonnault, PT, MS, DPT

=MOTION 1= Approve the agenda as printed.=PASSED=

=MOTION 2= Approve the business meeting minutes from CSM in Seattle, Washington February 6, 1999 as printed in Volume 11 Number 2 issue of *Orthopaedic Physical Therapy Practice*. =PASSED=

1. Clinical Residency Program Grants and Credentialing Update. For the year 2000, the Section has budgeted $10,000 for Clinical Residency Program Grants to offset the credentialing application fee.
2. Grants to Chapters for Legislative Support. The Orthopaedic Section is willing to accept requests for support to other components, special interest groups or individuals when the need affects the profession as a whole and specifically the Orthopaedic Section. This support could be financial, manpower, or utilization of publication resources. Specific criteria and procedures must be met. Each request is handled individually and there is no guarantee that support will be given. If you would like more information please contact the Section office.
3. House of Delegates 2000
   - Position on interventions exclusively performed by physical therapists. It is the position of the American Physical Therapy Association (APTA) that the scope of practice within physical therapy includes interventions that are exclusively performed by the physical therapist. These interventions encompass procedures including, but not limited to, spinal and peripheral mobilization/manipulation, which are components of the manual therapy techniques: and selected sharp debridement, which is a component of wound management.
   - Position on Continuing Education for Physical Therapist Assistant and Other Supportive Personnel. It is the position of the American Physical Therapy Association (APTA) to sponsor or support only those continuing education programs, paraprofessional career development opportunities, or educational products that are consistent with APTA's Standards of Practice for Physical Therapy, the Normative Models of Physical Therapist and Physical Therapist Assistant Education and other Board of Directors or House of Delegates approved documents. Such consistency shall be in the areas of course content, goals, objectives, target audience, and participants.
4. Fall Board of Directors Meetings
   In 2000 the Fall Meeting will include an evaluation and update of the Section's 3-year strategic plan. This year's meeting will be held in La Crosse, Wisconsin at the Section office. The Board of Directors voted to have this meeting alternate every other year between the Section office in La Crosse and APTA in Alexandria.
5. APTA Board Initiatives - Randy Roesch, APTA Board Liaison
   The primary initiatives are established through priorities set up at the House of Delegates. Current initiatives include:
   - 100% direct access across the country,
   - membership development campaign,
   - reimbursement - interface with HCFA on alternatives for $1500 cap,
   - research - approved clinical research agenda, and
   - assist states in turf battles on manipulation/mobilization/manual therapy

   The APTA approved and put together a strategic planning meeting on this. The strategic plan developed at this meeting was presented to the APTA Board of Directors. The Board approved funding for a task force, which includes members of the Orthopaedic Section Board of Directors, to keep this going.
6. The Section made a contribution of $5,000 to the Minority Affairs Capital Campaign in 1999. The Section also pledged 25% of the profit from the pediatric home study course being published in 2000 to go to the capital campaign

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

1. Nancy was appointed for a third year to the Foundation's Board of Trustees.
2. The Foundation for Physical Therapy conducted a call from members for funding for the clinical research small grants program. The Orthopaedic Section funded three and a half grants. The first was awarded to Dr. Timothy Flynn, the second to Dr. Jay Irrgang, the third to Dr. Phil McClure, and the half grant was joint with the Section of Geriatrics and was awarded to Dr. Kathleen Mangione.

C. Treasurer - Ann Grove, PT

See financial graphs.

D. Director - Joe Farrell, PT, MS

1. Coordinated the publication of 4 articles on the Section's 25th anniversary in *Orthopaedic Physical Therapy Practice* last year.
2. Attended the strategic planning meeting on manipulation held at APTA last September.
3. Attended the 5th conference of the AAOMPT last October that was co-sponsored by the Orthopaedic Section.

E. Director - Gary Smith, PT, PhD

1. Assisted in the development of a membership committee.
2. Gathered information on developing a charitable giving initiative for the Section.
3. Serve on the Advisory Council for home study courses.

F. Education - Lola Rosenbaum, PT, MHS, OCS

1. The Foot and Ankle SIG will be having a research retreat in May.
2. The Animal SIG will be having another canine course in June.
3. The Section has redefined the round table concept and renamed it a level 3

SIG. The Occupational Health SIG is a level 1 SIG and the Foot and Ankle, Pain, Performing Arts, and Animal SIGs are all level 2. Level 3 SIG has a less formal structure with no bylaws required and they do not have a business meeting. They do not publish a newsletter in OP and they do not need 200 signatures to form.

4. Approximately 25% of the registrants attending CSM are Orthopaedic Section members.
5. The following individuals were acknowledged and thanked for all the work they put into the programming for CSM:
   - Paul Howard, Ellen Hamilton, Gary Shankman, and Kim Dunleavy - members of the Education Committee
   - Ray Vigil - Education Chair for the Occupational Health SIG
   - Patty Zorn - Education Chair for Manual Therapy
   - Nick Quarrier - Education Chair for the Performing Arts SIG
   - Tom McPoil and Mark Cornwall - Foot and Ankle SIG
   - Cheryl Rieger-Krugh - Education Chair for the Animal SIG
   - Phil McClure - Research Committee
   - Chris Powers - Patelofemoral preconference course
   - Tara Fredrickson - Executive Assistant at the Section office
   - Linda Weaver - past Executive Secretary at the Section office

G. Research - Philip McClure, PT, PhD
See committee reports.

H. Practice - Steve McDavitt, PT, MS and Helene Fearon, PT

1. The main issue this past year was the chiropractors. The committee is looking for feedback from the membership on what issues this committee should be focusing on.
2. The Committee has completed 5 out of the 8 major objectives from their strategic plan.
3. Anyone interested in working with the Practice Committee is encouraged to contact Steve, Helene, or the Section office.

III. COMMITTEE REPORTS

A. Membership - Michael Wooden, PT

1. Michael Wooden is the new Chair of the Section's Membership Committee.
2. A goal of this committee will be to maintain a 2% growth rate in membership and maintain the members we currently have. The committee will also focus on an outreach to students and non-Section members who are currently APTA members.
3. The Chair is looking for individuals to serve on this committee. If you are interested please contact Michael Wooden directly or the Section office.

B. *OP* Editor - Susan Appling, PT, MS, OCS

1. Sharon Klinski was recognized as Managing Editor of *OP.*
2. A change in the publication schedule for *OP* to coincide more closely with the Section's Board meetings was implemented. The 4 issues will be CSM, Annual Conference, Fall Board Meeting, and one special issue.
3. If you are interested in writing an article for *OP,* please contact Susan Appling directly or Sharon Klinski at the Section office.

C. Orthopaedic Specialty Council - Jean Bryan, PT, PhD, OCS
See committee reports.

D. Home Study Course Editor - Carolyn Wadsworth, PT, MS, CHT, OCS

1. The 1999 home study courses are averaging 500 - 600 registrants.
2. All home study courses are kept current for 5 years and then retired. Our first courses to be retired averaged over 1,000 registrants each. The retired courses will be offered free to WCPT countries. Twenty-six are interested including countries affiliated with Health Volunteer Organizations.
3. Four courses are scheduled for 2000; Basic Science for Animal Physical Therapists which began in January, Orthopedic Interventions for Pediatric Patients to begin in April, Management of the Foot and Ankle will start in July, and Disorders of the Knee which will begin in October.
4. In 2001 we will be offering a shoulder course and a course on *Current Concepts of Orthopaedic Physical Therapy.* The current concepts course will contain 11 monographs instead of the usual six.
5. The Board approved two new courses for 2002. They are Prosthetics and Orthotics and Selected Diagnosis in Orthopaedics.
6. A special discount rate is being offered to PT and PTA libraries for $85 per course. They have the option of purchasing an additional copy of a course for $50 which grants copyright permission for use in the classroom.

E. Public Relations - Terry Randall, PT, MS, OCS, ATC

1. Terry Randall is a member of the Advisory Panel on Public Relations for APTA.
2. Student guest winner, Trevor Carlson, was introduced and public relations committee member were recognized.
3. See committee reports for additional information.

F. Nominations - Jean Bryan, PT, PhD, OCS

1. The total number of ballots cast for the 2000 election was 713. There were no invalid ballots. Joe Farrell was re-elected to a second term as Director and Bill O'Grady was elected as Nominating Committee Member.
2. Mary Wilmarth will be the new Nominating Committee Chair for 2000.
3. A call for nominations from the floor for the 2001 election was brought forth for the offices of president, vice president, and nominating committee member. No nominations were made.

G. JOSPT - Rick DiFabio, Editor-in-Chief

1. A total of 196 manuscripts were sent out for review in 1999; 40% of these were accepted. Each manuscript is reviewed 3 times before being accepted for publication.
2. JOSPT has started long-range planning for special issues. The special issue for 2000 will be on the cervical spine. For 2001 it will be on neuromotor control of the knee and 2002 sports injury and prevention.
3. International submissions to JOSPT have increased.
4. Currently in the process of developing a website for JOSPT. The goal is to make it interactive by the end of 2000.

UNFINISHED BUSINESS

None

NEW BUSINESS

=MOTION 1= The Orthopaedic Section will explore publishing consumer health information relative to common conditions treated by orthopaedic physical therapists on the Section web page.=PASSED=

=MOTION 2= Charge the Awards Committee to explore the development of a new or existing award that would reward an individual for both research and service to the JOSPT and to report back at the next Board of Directors meeting.=PASSED=

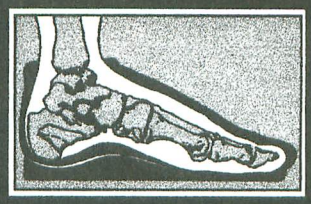
=MOTION 3=The Section Board of

(Continued on page 32)

HOME STUDY COURSE

Contemporary Topics on the Foot and Ankle

An Independent Study Course
Designed for Individual Continuing Education



Topics and Authors

Normal Anatomy and Pathophysiology of the Foot & Ankle *Robert Donatelli, PT, PhD, OCS*
Contemporary Footwear Considerations *Tom McPoil, PT, PhD, ATC*
Foot and Ankle Orthoses *Mark W. Cornwall, PT, PhD, CPed*
Injuries of the Leg, Foot, and Ankle *Joseph E. Tomaro, PT, MS, ATC*
Diabetic Foot Problems *Nancy Balash, PT, USPHS*
Inflammatory Arthritis: Management of Foot & Ankle Problems *Joseph A. Shrader, PT, CPed; Karen Lohmann Siegel, PT, MA; and Naomi Lynn Gerber, MD*

Editorial Staff

Carolyn Wadsworth, PT, MS, OCS, CHT—Editor

Deb Nawoczenski, PT, PhD—Subject Matter Expert

Course Description

This course offers a broad selection of clinical topics that are relevant to physical therapists at all levels of experience. The well known, highly respected authors discuss state-of-the-art techniques for managing foot and ankle dysfunction, including footwear and orthotic prescription. You will learn the fundamental mechanics of force attenuation during weight bearing and the ramifications of compensation secondary to deformity, injury, and sensory loss. This is an excellent means to update your clinical decision-making skills.

Continuing Education Credit

30 contact hours will be awarded to registrants who successfully complete the final exam.

Registration Fees

Register now! First monograph available in July.
$150 Orthopaedic Section Members $225 APTA Members $300 Non-APTA Members
WI residents add applicable state sales tax.

Special discounts offered for multiple registrants.
Contact the Section office for details.

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.

10.3 Contemporary Topics on the Foot and Ankle

Name_____ Credentials (circle one) PT, PTA, other _____
Address_____
City_____ State _____ Zip _____
Daytime Telephone Number (_____)_____ APTA # _____
E-mail Address _____

Please check:
❑ Orthopaedic Section Member
❑ APTA Member
❑ Non-APTA Member
(Wisconsin residents add applicable sales tax)

I wish to join the Orthopaedic Section and take advantage of the membership rate.
(Note: must already be a member of APTA.)
❑ I wish to become a PTA Member ($30)
❑ I wish to become a PT Member ($50)

Fax registration and Visa or MasterCard number to:
(608) 788-3965
Visa/MC (circle one)# _____
Expiration Date_____Amount _____
Signature _____

Mail check and registration to:
Orthopaedic Section, APTA, 2920 East Avenue South, Suite 200, La Crosse, WI 54601
Toll Free 877-766-3452

APTA American Physical Therapy Association

OP

Foot & Ankle Special Interest Group,
Orthopaedic Section, APTA, Inc.
proudly presents:

"Research Retreat 2000"

"Static and Dynamic Classification of the Foot"

May 19 - 20, 2000
Historic Inn * Annapolis, Maryland
410/263-2641 * Room Rates: $129.00/single * $149.00 double

OBJECTIVES:

The purpose of this retreat is to provide a forum for discussion on research topics related to the foot and ankle with the goal of providing direction for future research. This first research retreat will focus on static and dynamic classification of the foot with the following objectives:

- Based upon osteological studies of the foot, discuss the functional and clinical significance of anatomical variations in the subtalar joint
- Discuss previous and current research efforts to develop a static classification or alignment scheme (including foot shape, soft tissue characteristics, etc.) to predict dynamic foot movement
- Discuss previous and current research efforts to dynamically classify the foot using parameters such as motion magnitude, timing, etc.
- Discuss research focused on the relationships between static and dynamic function of the foot.

FORMAT:

The format will incorporate one hour podium presentations by the primary speakers with small group discussions to follow. A limited number of participants will be given the opportunity to present related research in 10 - 15 minute podium presentations. Abstracts of all research will be required and will be distributed to all retreat participants in the form of a meeting proceedings.

FACULTY:

Jan Bruckner, PhD, PT
Mark Cornwall, PhD, PT
Howard Hillstrom, PhD
Irene McClay, PhD, PT
Tom McPoil, PhD, PT, ATC

SCHEDULE:

Friday, May 19:
1:00 PM - 7:00 PM
Saturday, May 20:
8:30 AM - 5:00 PM

TUITION: $150.00

FOOT & ANKLE SIG RESEARCH RETREAT

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
APTA ID: _____ E-MAIL: _____
DAYTIME PHONE: _____ FAX: _____
Make checks payable to: **Orthopaedic Section, APTA, Inc.**

Please circle:
Master Card/Visa #: _____ Exp: _____
Signature: _____

Send to: Orthopaedic Section, 2920 East Ave. South, Suite 200, La Crosse, WI 54601
800/444-3982 * 608/788-3965 FAX

OPTIONAL ACTIVITY (Limited to 25 people):

Sunday Brunch Sail (May 21, 2000)
11:00 -1:00 Sail on 68 ft Schooner Liberte (Champagne, continental breakfast)
1:30 - 2:30 Full brunch served in the Chart House Restaurant
Sail-$25.00 * Sail and Brunch - $45.00 * Registrant guests welcome
IF INTERESTED IN SUNDAY ACTIVITY:
Please send **separate payment** to the Orthopaedic Section office

THE ANIMAL PHYSICAL THERAPY SPECIAL INTEREST GROUP, ORTHOPAEDIC SECTION

Proudly Presents:

"CANINE PHYSICAL THERAPY I"

JUNE 9 – 11, 2000
KNOXVILLE, TENNESSEE

COURSE DESCRIPTION:

This course is an introduction to the treatment of small animals, predominately dogs, for physical therapists. This 2 1/2 day course will include comparative anatomy, with labs on preserved specimen samples. The use of live dogs for laboratory experiences will be an integral part of this course. Proper safety and handling of the canine including restraints will be emphasized to enhance the learning process. **This course is intended for physical therapists and physical therapist assistants only.**

COURSE OBJECTIVES:

At the completion of this course, the registrant will be able to: 1) demonstrate proper safety and handling of the canine including restraints; 2) understand the legal issues regarding treatment of animals; 3) discuss the differences between anatomy of the human and the canine; 4) perform palpation of the canine identifying joints, muscles, ligaments, etc.; 5) perform basic evaluation techniques of the dog including range of motion, function strength, integrity of the nervous system, etc.; 6) perform basic gait analysis of the canine; 7) discuss and perform basic rehabilitation techniques on the canine.

SPEAKERS:

Siri Hamilton, VT, PT
Darryl Millis, MS, DVM
Joseph Weigel, DVM
David Levine, PhD, PT
Robert Taylor, MS, DVM

SCHEDULE:

Friday, June 9th: 9:00 AM – 5:00 PM
Hyatt Regency Knoxville
Saturday, June 10th: 9:00 AM – 5:00 PM
University of Tennessee, Knoxville (Lab session)
Sunday, June 11th: 8:00 AM – 12:00 PM
Hyatt Regency Knoxville

LOCATION:

Hyatt Regency Knoxville, Knoxville, Tennessee
423/637-1234
Room Rates: $89.00 single/double

REGISTRATION RATES:

Orthopaedic Section Member:	$250.00
APTA Member:	$325.00
Non-APTA Member:	$350.00

CONTINUING EDUCATION UNITS:

18 Contact Hours

CANCELLATION POLICY:

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.

SPACE IS LIMITED—REGISTER SOON! **SPACE IS LIMITED—REGISTER SOON!**

"CANINE PHYSICAL THERAPY I"

NAME: _____
ADDRESS: _____
CITY: _____ **STATE:** _____ **ZIP:** _____
Please Check: ☐ Orthopaedic Section Member ☐ APTA Member ☐ Non Member
APTA ID: _____ **E-MAIL:** _____
DAYTIME PHONE: _____ **FAX:** _____
Make checks payable to: Orthopaedic Section, APTA, Inc.

Please circle:
Master Card/Visa#: _____ Exp: _____
Signature: _____

Be sure to check out the Animal Physical Therapy SIG's Home Study Course, "Basic Science for Animal Physical Therapists" for additional information on Animal Physical Therapy!

Orthopaedic Section, APTA, Inc., 2920 East Ave. South, Ste. 200, La Crosse, WI 54601
800/444-3982 * 608/788-3965

STRETCH YOUR MIND

Orthopaedic Section, APTA — Home Study Course Series

History

The Orthopaedic Section, APTA, Inc. offers excellent continuing education through its Home Study Course series. Since 1991 we have been providing clinicians, faculty, and students with a stimulating choice of contemporary professional topics. Each course comprises comprehensive monographs that address different aspects of the topical area. Our carefully selected authors are experts in their respective fields.

How It Works

Each home study course includes 6 monographs and a binder to hold the course materials. Each monograph averages 20-28 pages in length and requires 4 to 6 hours to complete. All monographs contain 10 self assessment multiple-choice questions (answers are on the last page) . Upon completion of the course, registrants receive a final examination containing 24 multiple-choice questions. To receive continuing education, registrants must complete the examination and return the answer sheet and the CEU form and must score 70% or higher on the exam. Registrants who successfully complete the exam will receive a certificate recognizing the contact hours earned. Only the registrant named on the registration form may obtain contact hours. Registrants are responsible for applying to their State Licensing Board for CEUs.

For courses in progress, registrants receive monographs monthly and must return their exam within 4 weeks of receiving the final monograph. For completed courses, registrants receive all 6 monographs and must return the exam within 90 days.

HOME STUDY COURSE

APTA American Physical Therapy Association

Continuing Education Credit

30 contact hours will be awarded to registrants who successfully complete the final exam.

Completed Courses Currently Available

HSC 96-1 The Cervical Spine
HSC 96-2 Topics in Orthopaedic Physical Therapy Assessment
HSC 97-1 The Hip & Sacroiliac Joint
HSC 97-A Clinical Approach to Management of Arthritis (This is a 3 monograph course. Contact the Section office for fees.)
HSC 97-2 The Elbow, Forearm & Wrist
HSC 98-1 Occupational Health
HSC 98-A Strength & Conditioning Applications in Orthopaedics
HSC 98-2 Pharmacology
HSC 9.1 Diagnostic Imaging of Bones & Joints
HSC 9.2 Orthopedic Interventions with Seniors
HSC 9.3 Managing Lumbar Spine Dysfunction

2000 Courses

HSC 10.1 Basic Science for Animal Physical Therapists (January-June 2000)
HSC 10.2 Orthopedic Interventions for Pediatric Patients (April-September 2000)
HSC 10.3 Contemporary Topics on the Foot & Ankle (July-December 2000)
HSC 10.4 Disorders of the Knee (October 2000-March 2001)

2001 Courses

HSC 11.1 Solutions to Shoulder Disorders
HSC 11.2 Current Concepts of Orthopaedic Physical Therapy

Editor: Carolyn Wadsworth, PT, MS, OCS, CHT

Registration Fees

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

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.

Special discounts offered for multiple registrants. Contact the Section office for details.

REGISTRATION FORM

Course #: _____ APTA #: _____

Name: _____ Credentials: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Daytime phone : _____ E-mail address: _____

Please check:
☐ Orthopaedic Section Member
☐ APTA Member
☐ Non-APTA Member
WI residents add sales tax.

I wish to join the Orthopaedic Section and take advantage of the membership rate. (Must already be an APTA member.)
☐ I wish to become a PTA Member ($30)
☐ I wish to become a PT Member ($50)

Fax registration and Visa or MasterCard number to 608/788-3965 or phone toll free 877/766-3452.
Visa/MC # _____
Exp. _____ Amount _____
Signature _____

OP

Please make checks payable to Orthopaedic Section, APTA.
Mail check and registration form to Orthopaedic Section, APTA, 2920 East Avenue South, Ste 200, La Crosse, WI 54601.

EDUCATION COMMITTEE REPORT

Attendance at the Combined Sections Meeting in New Orleans was excellent. We had approximately 4,600 attendees so sessions were full. If you missed a session you may order an audiotape of that session from Dreamline Productions (phone: 949-642-4919 or e-mail: dptapes@aol.com). Handouts for most sessions are available on the Orthopaedic Section web site (www.orthopt.org).

Upcoming courses include a research retreat and an educational course sponsored by the Foot and Ankle SIG, and a canine course sponsored by the Animal Health SIG. Contact the section office for further details.

Level 3 SIGs are now incorporated into the Orthopaedic Section SIG structure. This SIG would be for educational purposes and would not be required to establish bylaws, have a board or business meeting, or submit articles for *OP*. Level 3 SIGs would be able to schedule 3 hours of educational programming during CSM. If you are interested in scheduling programming please contact the Orthopaedic Section Education Program Chair.

The Education Committee has been asked to form a task force to develop a model curriculum for orthopaedic residencies. The intention of the model curriculum is to assist developing residency programs. It is not intended to be used as requirements for residency curriculums. Paul Howard, PT, PhD will be the liaison for this task force.

Lola Rosenbaum, PT, MS, OCS
Education Committee Chair

RESEARCH COMMITTEE REPORT

We again received an excellent response for platform and poster presentations and the quality and quantity continue to improve. We received 80 abstract submissions for platform presentations and 50 were accepted for presentation. There was approximately the same number of abstracts for posters. There are still a few bugs to work out of the review process because many decisions must be made in a very short time period to meet publication deadlines.

There were 8 proposals submitted this year for the Clinical Grants program (3 for $5000 and 5 for $1000). The final decision after the external reviews was to fund only 1 application. The application funded is: PROJECT TITLE: Reliability, Validity, and Responsiveness of the DASH (Disabilities of the Arm, Shoulder and Hand) Principal Investigator: John Schmitt, MS, PT and Co-investigator: Richard P. Di Fabio, PhD, PT. The number of proposals submitted continues to be relatively low and the reasons for this are unclear.

I would like to publically thank Tony Delitto, Rick DiFabio and Karen Hayes who served as external reviewers for this grant process for the previous 3 years. They did an excellent job on a difficult and labor-intensive task.

The Section is currently exploring the possibility of supporting another Clinical Research Center with the Foundation for Physical Therapy.

Phil McClure, PT, PhD
Research Chair

SPECIALIZATION COMMITTEE REPORT

A new member was welcomed to the committee—Robert Johnson came onto the Orthopaedic Specialty Council in July '99.

The ABPTS has proposed changes in the professional development portfolio requirements for recertification. Previously we had required 50 points. There was disparity between specialties from 25 to 50—Orthopaedics was the highest. To keep things more consistent, we proposed to lower the points to 35, by proportionally lowering the maximum points that could be earned in any one area. The council feels comfortable that this plan will require specialists to continue their professional development in more areas than just direct patient care and continuing education. We also recommended more points for writing exam questions to help offer more incentive and more involvement.

Our plan for Review/Revision/Revalidation of the current Orthopaedic DACP was approved by ABPTS and the work group to review/revise and develop the survey will meet January 7-9, 2001. Serving on this group are the Council members (Bob Johnson, Mike Cibulka, me), Bill O'Grady, Nancy Henderson, Subrina Linscomb, Robert Landel, David Boyce, and Aimee Klein. Part of the work group's task will also be to "guidicize" the document.

We have recently reviewed all exam questions to put them in *Guide* language for the 2001 exam.

While we fought valiantly for no change to our requirement to sit for the exam, we were not able to get a stay of execution. However, from the October ABPTS meeting, the council left feeling that the change to 2000 hours can work even though we do not agree with it. MOST important, we have firm commitment from the board, that they will NOT change the cut score that we, the orthopaedic specialists set, AND that we can set the review criteria to relook at the requirement in 3 years.

Jean M Bryan, PT, PhD, OCS
Orthopaedic Specialty Council Chair

PUBLIC RELATIONS REPORT

The use of the exhibit booth has changed in the past year. We have targeted various physician specialities over the past few years. I have now targeted the physician assistants and nurse practitioners. These groups represent a large potential referral source for patients in need of a physical therapist. They are also more receptive to our message and open to our suggestions.

I attended the nurse practitioners meeting in Nashville on October 7-9. This was a very good opportunity to make contact with professionals that have the capability to make a positive impact on their patients by referring them to a physical therapist. In addition I have been invited to their next conference and will be conducting a musculoskeletal clinic in exchange for free exhibit space. I will be providing several sessions on management of musculoskeletal disorders.

On October 22 - 23 the booth was displayed at the Student Conclave. The Student Conclave is an exciting meeting for PT and PTA students who are generally eager to find out more information about the benefits of joining the Orthopaedic Section. This meeting is crucial for maintaining our student membership.

The next PA conference is in Chicago, May 27 - 29. This was a well-attended conference last year and a wor-

thy target audience for our PR efforts.

There is a great deal of interest in the development of our Section's web page. Please contact a PR committee member, the Section office, or me and provide input on the type of information/services you would like to see on our web site.

I would also like to thank Rick Watson, Patrick Zerr, and Michael Tollan for their interest in, and help with, the PR Committee.

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

NOMINATING COMMITTEE REPORT

The nominating process is on target. Again, we had difficulty getting nominees for the Board of Director's position such that Joe Farrell ran unopposed. The good news is that during the nomination process, we had several potential candidates who turned us down but expressed future interest for specific positions.

We continue to work to build the pool of potential candidates. We are planning a mailing to all orthopaedic certified specialists in February to begin planning for the fall 2000 election. Calls for nominations in *OP* has not generated much return; however, we would like to continue it for the next year. We continue to work on recruitment for potential candidates who are minorities as well. One venue that we have taken advantage of is getting more minority orthopaedic certified specialists involved with the Orthopaedic Specialty Council, so our pool of potential candidates is slowly increasing.

Jean M Bryan, PT, PhD, OCS
Nominating Committee Chair

CSM 2000
Business Meeting Minutes

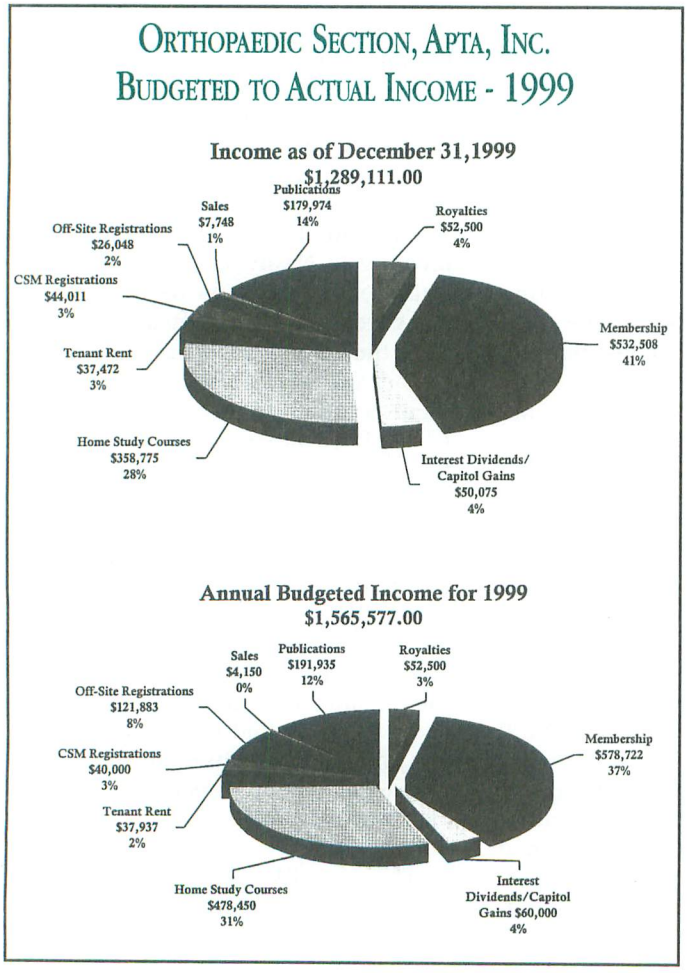
(Continued from page 26)

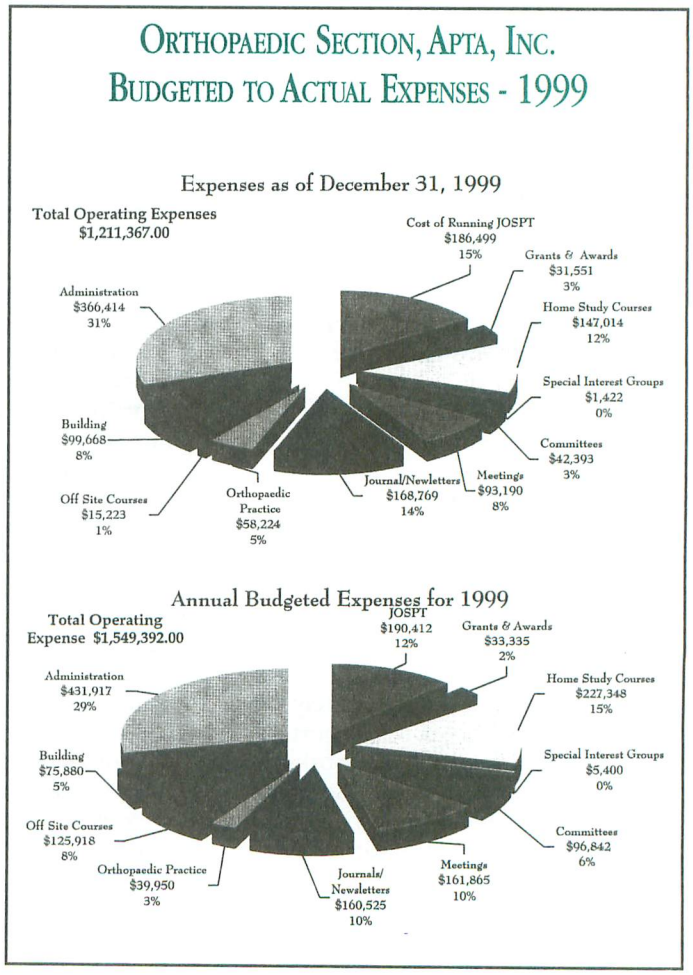
Directors will explore physical therapists practicing in multiple jurisdictions within the United States and internationally and report back to the membership at CSM in 2001.=PASSED=

=MOTION 4=The Section investigate and move toward trade marking/service marking the term "orthopaedic physical therapy". =PASSED=

ADJOURNMENT
10:30 AM

FINANCE REPORT





OCCUPATIONAL HEALTH
PHYSICAL THERAPISTS
SPECIAL INTEREST GROUP

ORTHOPAEDIC SECTION, APTA, INC.

Summer 2000 Volume 12, Number 1

President's Report

The new millennium, a time for the 3 Rs: Re-grouping, Re-focusing, and Re-energizing! Last year was a time of transition for the Occupational Health Special Interest Group (OHSIG). Our Board of Directors experienced some resignations in 1999 and the transition was a bit rocky. However, new officers have been elected, vacancies have been filled by appointment, and we look forward to the year 2000 as an exciting and dynamic time for the OHSIG. The new board combines some old members in new positions and new members who have stepped up to the plate. (See the list of officers on page 35.) The Business Meeting addressed some important issues and the membership charged the Board of Directors with some important tasks. The Board of Directors meeting carried those charges forward with specific action plans and deadlines.

Here are some of the highlights:

Additional Board of Directors Meetings for 2000: To help us improve communication and stay focused on our strategic plan, we budgeted additional funds to have 2 face-to-face board meetings this year, one at PT 2000 in Indianapolis in June and a retreat in the fall. In addition to the face to face meetings, the BOD will have quarterly phone conferences. Our new Vice President, Bonnie Sussman, is committed to seeing that we stay focused on our strategic plan. Bonnie and I will have monthly phone conferences to help maintain the focus.

Upcoming OHSIG Newsletter Topics: Possible topics for upcoming issues of the OHSIG Newsletter in *OPTP* include Synopsis and Response to OSHA Ergonomic Guidelines, Cultural Considerations in Treating the Injured Worker, O'NET: The Replacement for the Dictionary of Occupational Titles, Outreach: What Are Our Goals? The OHSIG welcomes contributions for the newsletter from the membership. Topics can include anything of interest in the area of occupational health physical therapy. Just submit to the OHSIG Secretary, Michael Emmons House (see contact information below). If you have ideas but want input prior to submission, feel free to contact any of the board members for advice or suggestions.

Topic for CSM 2001: There was a strong feeling among OHSIG members that the primary focus of educational programming for CSM 2001 be the OSHA Ergonomic Guidelines. Even if the guidelines do not pass congress, their content will undoubtedly have influence on the way industry thinks about the practice of ergonomics. Certainly if they pass, the guidelines will create opportunities for therapists. Our hope is to have someone from OSHA present, followed by presentations from physical therapy leaders in the field.

Ergonomics Certification: With the passing of the OSHA Ergonomic Guidelines on the horizon, the opportunities for physical therapists who are competent in ergonomics are increasing. However, a question arises. Who determines competency? Currently, the Board of Certification in Professional Ergonomics (BCPE) offers 2 levels of certification: the Certified Professional Ergonomist (CPE) and the Certified Ergonomics Associate (CEA). The requirements for the CPE are a master's degree in ergonomics or human factors, documentation of project involvement, 4 years of full-time practice in ergonomics, and passing a written examination. These requirements exceed the level of involvement that is realistic for most practicing therapists. Many therapists already have masters' degrees in other areas and do not practice exclusively in ergonomics.

More recently the BCPE developed another level of ergonomics certification, the CEA that requires a bachelor's degree, 200 contact hours of ergonomics training, 2 years of full-time professional practice, documentation of project involvement, 4 years of full-time practice in ergonomics, and passing a written examination. Despite these fairly rigorous requirements, the scope of practice delineated by the CEA seems restrictive. For example the CEA is not allowed to work with "complex or nonconventional problems," "develop or apply advanced methodologies or mathematical models," work in a "broader systems design model," or design/redesign new work stations. Many therapists who are not CPEs currently practice competently in at least one of these areas.

Thus neither BCPE certification option seems to fit the typical physical therapist who has taken continuing education courses in ergonomics, has experienced on-the-job training in ergonomics, and practices ergonomics as part of a comprehensive concentration in industrial rehabilitation. Other professional societies are beginning to develop their own certification processes in ergonomics, which clearly establish ergonomics as an area of expertise for their professions. The American Industrial Hygiene Association currently has its own ergonomics certification process. The American Occupational Therapy Association is considering developing its own certification.

Thus, the question is raised: Should the APTA develop

some type of certification process in ergonomics? The advantages of such a certification are that it clearly establishes the role of physical therapists as ergonomists. However, such a certification would be costly to our national association. The OHSIG invites commentary and input regarding the membership's opinion on this issue. This topic will be one that we will, hopefully, address in a forum at national conference in Indiana this year. Watch the next OHSIG newsletter for an announcement as to date and location. We hope to hear from the members on this topic and see you at the upcoming forum.

O'NET: The Dictionary of Occupational Titles (DOT) is slated to be replaced with the newly developed O'NET. If you are not familiar with the O'NET, you may want to go the Department of Labor's web site and take a look (www.doleta.gov/programs/onet). The O'NET will be a drastic change in the way the physical demands of work are classified. You may be thinking that such a change will not affect you very much since you seldom use the DOT. Instead you may rely on patient self-report or job demands analysis to determine the physical demands of the job. However, O'NET may change the way you are required to analyze a patient's functional abilities in an FCE. For example, instead of determining the amount of force a patient can exert in lifting, carrying, pushing, and pulling, you may be asked to rate the patient's "static strength" on a scale from 1 to 7 with "1" meaning that he can "push an empty shopping cart" and "7" meaning that he can "lift a 75-pound bag of cement onto a truck."

The classification system on which O'NET is developed is one that is geared toward self-report of the worker, not quantitative job demands analysis. Can you imagine trying to assess patient abilities through self-report or having to translate your quantitative measures of function into a vague ordinal scale? If you are not familiar with O'NET, now may be the time to educate yourself and provide some feedback to the OHSIG regarding your opinions. Over the coming year, the OHSIG will be sponsoring discussion forums and polling other organizations such as AOTA, VEWAA, and NARPPS regarding their views on the usefulness of O'NET for rehabilitation assessments and disability determination. Let us hear from you.

So if you've been thinking that there's nothing new happening in the area of Occupational Health Physical Therapy, think again! The field is alive and well with a number of challenging and controversial issues surfacing and opportunities expanding. The coming year promises to be an exciting one and we look forward to increased participation from you all!

Deborah E. Lechner, PT, MS
President, OHSIG

Occupational Health Guidelines & Documents from APTA & OSHA

by Bonnie Sussman, OHSIG Vice President

DID YOU KNOW...

APTA, in cooperation with the Orthopaedic Section's Occupational Health Special Interest Group, has developed and approved several documents that apply to Occupational Health Physical Therapy? And, that these documents are available FREE to APTA members? Here is what is available, and how to get them:

1) *Position on the Use of Back and Wrist Supports* (BOD 06-95-03-05)
2) *The Role of the Physical Therapist in Occupational Health* (BOD 03-97-27-71)
3) *Occupational Health Guidelines: Evaluating Functional Capacity* (BOD 11-97-16-53)
4) *Occupational Health Guidelines: Physical Therapy Management of the Acutely-Injured Worker* (BOD 03-99-16-51)
5) *Occupational Health Guidelines: Work Conditioning and Work Hardening Programs* (BOD 03-99-16-49)

To access via Internet:

1) Go to APTA's Web site (**APTA.ORG**).
2) Click on **PT PRACTICE** on the menu on the left of the home page.
3) Click on **PROVISION OF PT SERVICES**, then **LINK TO BOD AND HOD POLICIES.**
4) Click on **PROFESSIONAL & SOCIETAL**, then scroll down to **PRACTICE.**
   Here you'll find the first 2 documents listed above. You may print or download these for your own use.
5) Next, scroll further down to **GUIDELINES**, then **PRACTICE.**
   Here you'll find the remaining 3 documents listed.

NO INTERNET ACCESS? You can obtain these documents in hard copy FREE (if you are a member) from APTA. Call APTA (1-800-999-2782) and go to the Governance office (ext. 8527). You can request any of the documents by name - it helps to include the identification number as well.

WANT NICER COPIES? *Occupational Health Guidelines: Evaluating Functional Capacity and Occupational Health Guidelines: Work Conditioning and Work Hardening Programs* are also available for sale in published form through the APTA publications department - $7.50 for members, $10.00 for non-members.

And, coming soon: *Occupational Health Guidelines: Legal & Risk Management Issues* and *Occupational Health Guidelines: Injury Prevention.*

Also on the docket for later this year: *Ergonomic Guidelines*

HAVE YOU BEEN HEARING ABOUT....

OSHA's Proposed Ergonomic Standard? APTA, with the help of 10 members (3 of whom are on the OHPTSIG Board), is in the process of drafting a written comment on the proposed standard, as well as preparing to testify at public hearings. More on APTA's response in the next newsletter. In the meantime, you can view the proposed standard in its entirety by going to OSHA.GOV - It's the first thing on the home page, or contact the Orthopaedic Section office if you want a hard copy and don't have Internet access. (Be prepared for a LONG read!!!)

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MEMBERSHIP
open

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 a 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.

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

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 program within that sponsor's area (when possible), or to sponsor's school preference if indicated.
3. School liaison will coordinate with the students interested in participating; assisting with matching the student with a sponsor.
4. School will forward student's 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.

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 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 Center (Inpt.)
_____ Rehab Center (Outpt.) _____ School System _____ Industry _____ Other _____

PLEASE RETURN TO:

ORTHOPAEDIC SECTION, APTA, INC.
2920 East Avenue South, Suite 200
La Crosse, WI 54601

FOOT & ANKLE

SPECIAL INTEREST GROUP
ORTHOPAEDIC SECTION, APTA, INC.

Greetings Everyone!

It seems as though the FASIG board members spend all year getting prepared for the CSM FASIG activities and before you know it, the meeting comes and passes so quickly. Again this year, as in years past, both the FASIG educational program as well as the business meeting were extremely successful and productive.

As usual, Mark Cornwall, Vice President, did an exceptional job in organizing the case study series that was presented during the FASIG educational programming session. A special thanks to all of the presenters including, Jim Birke, Michael Mueller, Susan Appling, Joe Schrader, and Mark Cornwall. The case study sessions were extremely well received with over 350 attendees at each session. In addition to the formal CSM FASIG activities, the FASIG also cosponsored with the Orthopaedic Section a preconference workshop entitled "Foot & Ankle Dysfunction: Evaluation & Management of Diabetic, Arthritic, and Orthopaedic Disorders." It was also very successful judging from the comments and course evaluations provided by the 60 individuals who attended.

As I previously noted, the FASIG business meeting was also quite productive with over 20 members attending at the conclusion of the Friday evening programming. While the official minutes of the meeting are attached to my report, I did want to give you a few of the highlights of the business meeting.

In my report, I noted that the American Orthopaedic Foot & Ankle Society (AOFAS) has assigned Judith Baumhauer, MD, to be the official liaison with the FASIG. I also noted that the FASIG, in partnership with the AOFAS, is planning to sponsor a foot & ankle symposium with speakers from both of our groups at a future CSM meeting. Steve Reischl has agreed to serve as the FASIG liaison to the AOFAS because of his close ties to the current President of the AOFAS. I also reported that in the past year, I also have had communication with the Canadian Pedorthic Association and hope to establish a continuous dialogue with their president. Finally, the membership recognized Mark Cornwall, outgoing Vice President, and Nancy Henderson, outgoing Chair of the FASIG Nominating Committee, for their outstanding service and commitment to the FASIG. Prior to stepping down as Chair of the Nominating Committee, Nancy reported the results of this year's election of officers. She reported that Mark Cornwall was re-elected Vice President and that Byron Russell was elected to serve on the nominating committee.

Mark Cornwall, Vice President, reported a site to hold the second 2½-day Foot & Ankle Seminar (identical to the course held at NIH in November 1998) in the Chicago, IL area has been located. Rush-St. Luke's Medical Center Physical Therapy Department has tentatively agreed to host the meeting in October 2000. Working with Irene McClay, Mark also reported that plans have been finalized for the FASIG sponsored research retreat that will be held in Annapolis, MD on May 19-20, 2000. Irene and Mark have worked extremely hard to get the retreat off the ground. It promises to be a stimulating event. Mark also requested that ideas for upcoming CSM programming be sent to him via email (Mark.Cornwall@nau.edu) or fax (520.523.9289). Mark also reported that the FASIG home page continues to be an active site. The web page provides excellent exposure to both the FASIG as well as the Orthopaedic Section.

Finally, Steve Reischl presented to the membership a draft of a survey that will eventually be sent to the Orthopaedic Section membership. The survey would be used to establish a database of physical therapists currently providing various levels of foot and ankle care. In addition to gaining insight into the number of therapists actively involved in providing foot and ankle services, the information obtained from the survey would be used in developing a referral data base of physical therapists who can provide various levels of foot and ankle care. Steve Reischl has agreed to chair a subcommittee to develop the draft and final copies of this survey. Our plan is have the survey sent to the membership this spring or fall and present the results to the membership at the next CSM meeting in San Antonio. Please contact Steve by email (reischle@earthlink.net) if you have any questions or comments on the proposed survey.

In future issues of *Orthopaedic Physical Therapy Practice*, look for foot and ankle case studies presented by the members of the FASIG. The purpose of these case studies is to stimulate discussion and debate regarding foot and ankle evaluation and management. If you would like to present a case study in a future issue of *OP*, please contact either Mark Cornwall or me.

In closing, I encourage all of you with an interest in the Foot & Ankle to become actively involved with the FASIG. The success of the FASIG is directly related to the involvement of the Orthopaedic Section members such as you! If you have any questions, suggestions, or comments regarding FASIG activities or upcoming events, please do not hesitate to contact me.

Best Regards as Always,
Tom McPoil

Minutes of the Foot and Ankle Special Interest Group (FASIG) Meeting
February 4, 2000
Combined Sections Meeting of the APTA
New Orleans, LA

The meeting was called to order by Tom McPoil at 5:08 pm. There were 13 individuals in attendance.

Motion: It was moved by Susan Appling and seconded by Byron Russell to approve the minutes of the February 4, 1999 meeting of the FASIG in Seattle, WA.

Passed by unanimous vote.

Officer/Committee Reports:

- Chair: Tom McPoil reported on continued efforts to better the relationship between the Foot and Ankle Special Interest Group (FASIG) and the American Orthopaedic Foot and Ankle Society (AOFAS). Steve Reischl has agreed to serve as a liaison between the 2 groups. Steve presented an overview of his past as well as future efforts.
- Vice-Chair: Mark Cornwall reported on the success of this year's programming and asked for input with respect to subsequent meetings. It was estimated that over 350 individuals attended the 4-hour block of programming provided by the SIG. It was also reported that future programming will include a Research Retreat in May 2000.
- Secretary/Treasurer: Tom McPoil provided the Secretary/Treasurer report in the absence of David Sims who was not able to attend. It was reported that the SIG continues to have sufficient financial resources budgeted by the Orthopaedic Section to accomplish their goals and objectives. Because of this, no change in the budget for next year has been requested. In addition, there is sufficient money available as a result of past programming efforts to fund projects or activities that are deemed important, but not budgeted by the Section.
- Research Committee: Irene McClay reported on the status of the Research Retreat that is planned for May 19-21, 2000 in Annapolis, Maryland. The theme or focus of the retreat will be "Static and Dynamic Classification of the Foot." She indicated that the program is set and 16 abstracts have already been submitted by individuals who wish to do platform presentations. Keynote speakers will be Tom McPoil, Mark Cornwall, Jan Bruckner and Howard Hillstrom. She has received a number of inquiries regarding attendance so all indications are that it will be a great success.

Old Business

- The members present asked that the foot and ankle terminology developed by Joe Tomaro be published in *Orthopaedic Physical Therapy Practice* for distribution to the membership. Tom McPoil stated that he would see that it was done.
- Steve Reischl presented on his efforts to conduct a survey of the Orthopaedic Section membership. The purpose of the survey is to get a better idea of the number of therapists with a background and interest in conservative foot and ankle care. A draft of the survey was distributed to the membership for suggestions, addition, and/or corrections. The survey will be mailed to the membership within the next few months. A report on the results of the survey will be presented to the membership at the next CSM meeting in San Antonio, TX 2001. Mark Cornwall will pursue an effort to offer an incentive to individuals to complete the survey when they receive it.

New Business:

Irene McClay, Steve Reischl, and Gary Hunt agreed to provide written patient case studies for publication in *Orthopaedic Physical Therapy Practice* over the next year.

Elections: Tom McPoil formally thanked Mark Cornwall and Nancy Henderson for their service to the SIG over the last 2 to 3 years. Because the number of individuals running for office were the same as positions open and no additional nominations were made from the floor, it was moved by Tom McPoil and seconded by Nancy Henderson to accept the slated nominees as being elected without holding individual elections or the use of ballots.

Passed unanimously. The results are therefore as follows:

Vice Chair: Mark Cornwall

Nominating Committee: Byron Russell

It should be noted that Steve Paulseth will serve as the Chair of the Nominating Committee until CSM in San Antonio, TX 2001.

With no further business, old or new, the meeting was adjourned at 6:10 pm.

Respectively submitted,
Mark Cornwall
Vice President, FASIG

FOOT & ANKLE OFFICER LISTING

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Performing Arts Special Interest Group • Orthopaedic Section, APTA

President's Message

Welcome back from New Orleans. I hope that those of you who attended CSM 2000 had a good time and enjoyed the programming. The PASIG was quite busy at CSM, not only with education sessions, but also with strategic planning for our interest group. We were thrilled to see so many of you at our business meeting, and as always, welcome more participation from the rest of our membership. For those of you who were not present, Nick's summary of programming and the minutes from the business meeting should bring you up to speed. I would also like to highlight a few items.

I want to thank the Executive Board for all their hard work. Nick, Jeff, and Shaw have been indefatigable in their efforts to meet our objectives this year. I also want to recognize our outgoing secretary, Shaw Bronner, for all of her contributions to the SIG over the past 5 years. As many of you know, Shaw stepped down from her position at CSM 2000. She had one year to go in her term; the Executive Board appointed Donna Ritter to serve out the remaining year. Shaw made invaluable contributions to this SIG, including developing the membership directory, leading the efforts to profile our membership, spearheading our initial investigations into performing arts mentorships and fellowships, contributing to our educational programming, and so much more. We will miss her, but we send her off with our best wishes as she pursues her doctorate, as well as other dance medicine research initiatives. We also welcome Donna to the Executive Board.

Thanks also go out to all the others who worked behind the scenes for the PASIG this year, including Enid Woodward and Donna Ritter for chairing the Fellowship and Mentorship Task Forces, respectively, as well as Marshall Hagins, Julie Daugherty, Stephania Bell, Martha Brown, Lynn Medoff, Julnar Rizk, Alice Burton, Jill Olsen, Nancy Byl, Linda Van Dillen, and Kathy Roach.

With regard to other business, there are 2 items worth mentioning. First, the Orthopaedic Section Practice Committee will be investigating national interstate licensing issues of interest to the PASIG membership. Second, the PASIG membership voted to undertake a formal practice analysis in order to identify the clinical breadth and depth of a performing arts therapist. This will help us immeasurably with future efforts to develop mentorships or fellowships. We will apply to the Orthopaedic Section for money to fund this effort, which includes surveys, facilitated meetings with content experts in our field, and more. We will keep you posted.

In closing, I ask all of you to consider participating in the SIG this year. Each committee has room for members to become involved at whatever level of commitment you are able to make. Many hands make light work, and we do have some work to get done.

Respectfully yours,
Jennifer M. Gamboa, MPT
President

CSM 2000 PASIG Programming Success!

Throughout the night, the sounds of music and dance filled Bourbon Street, while during the day, lively discussions of music and dance reverberated through the convention center in New Orleans! The PASIG presented 4 solid hours of well-attended educational programming. Micky Cassella and Christine Ploski presented an informative discussion on idiopathic scoliosis in adolescent ballet dancers. Susan Robinson played beautiful music on her viola while Margaret Pittinger explained and demonstrated Feldenkrais interventions. Lynn Medoff shared her techniques to enhance deep breathing. Nick Quarrier demonstrated athletic taping techniques for dancers' feet and musicians' wrists. The program finale involved a lively panel of distinguished researchers: Nancy Byl, Katherine Roach, and Linda Van Dillen. They examined and critiqued 4 clinical research projects presented by Julie Daugherty, Faye Dilgen, Martha Brown, and Peter Edgelow.

The PASIG is already gearing up for another exciting and fruitful educational program for CSM 2001.

Nick Quarrier, PT, MHS, OCS
Vice President

2000 PASIG Business Meeting Minutes
Combined Sections Meeting
New Orleans, Louisiana
2/4/00
6:30 p.m.

1. Call to order and Welcome: Jennifer Gamboa, President.
   Introduction of the Executive Board and of Paul Howard, the Vice Chair of Education and Program Committee for the Orthopaedic Section.
2. 1999 Annual PASIG Business Meeting Minutes.
   Motion passed to approve the minutes as printed and reviewed by the membership.
3. 1999 Treasurer's Report: Jeff Stenback, Treasurer.
   - The most recent budget report available was within budget. The final 1999 budget report will be published in *OP* as soon as it is available.
   - The 2000 budget has been approved by the Orthopaedic Section (projected budget follows below).
   - The PASIG would like to establish a mechanism to bring in additional funds to expand programming.
4. Executive Committee: Jennifer Gamboa, President
   - Possible mechanisms of establishing a regular means of communication, eg, e-mail communiques, with the membership-at-large are being explored.
   - Development of outreach opportunities to other Performing Arts Medicine organizations are underway.
   - The committee faciliated revisions of the PASIG Webpage.

   The Chairs of the Standing and Special Committees were asked to report.
5. Public Relations/Media Relations Committee: Jeff Stenback, Chair
   A logo by which the PASIG could be identified and marketed was created.
   - Pins with the PASIG logo and the PASIG 2000 Membership Directory with the logo on the cover are now available.
   - The PASIG brochure was completed. It is a trifold mailer with the PASIG logo on the front, and includes information regarding dance and music medicine, and contact information for the PASIG.
     These items are excellent tools for use in marketing to performing arts companies, dance/music teachers, and schools.
     Efforts directed toward disseminating information about what physical therapists do and are helpful in their work with performing artists.
   - Members contributed articles for *OPTP* describing experiences with regional and touring dance companies.
   - The committee is working toward getting articles into local publications that might be interested in what we do.
6. Practice Committee: Shaw Bronner, Chair
   - The Membership Directory was updated. Members were asked to contact the Committee with further corrections and updates for the directory.
   - Mentorship and Fellowship Task Forces developed proposals and options. A Summary of the task forces' activities was distributed to the meeting attendees.
   - A Student Affiliation Site List was compiled by Donna Ritter, which is included in the new Membership Directory and will be available on the PASIG Website.

Mentorship Task Force Report: Donna Ritter, Chair

In the past year, proposals for both formal and informal mentorship programs were developed. The formal mentorship included criteria and guidelines for requirements, content, and competency. The informal mentorship described the mentor/protege relationship and explored means for implementation.

Fellowship Task Force Report: Enid Woodward, Chair

The main focus was to gather information on exactly what was involved in developing a Fellowship. OCS vs. non-OCS pathways were examined. Requirements, content, competency criteria, and guidelines were explored. Some overlap with mentorship was recognized and a recommendation was made to merge the Mentorship and Fellowship Task Forces.

7. Education Committee: Nick Quarrier, Chair
   Reported on a year of hard work to create 4 hours of solid PASIG programming planned for the following day.
8. Research Committee: Jennifer Gamboa, Chair
   The objective continues to be the fostering of performing arts research, particularly for those practitioners who are not affiliated with an educational institution.
9. Nominating Committee: Donna Ritter, Chair
   - The new committee Chair will be Amy Wightman.
   - Two new Nominating Committee members were elected at the meeting: Lynn Medoff for a 1-year term and Martha Brown for a 3-year term.
   - Elections will be held this year for Vice President, Secretary, and Nominating Committee member for 2001.
10. Recognition:
    Jennifer Gamboa recognized the membership's involvement in working to make the PASIG a visible and contributing member of the Orthopaedic Section.
    - Special recognition was accorded Shaw Bronner, who was presented with a plaque from the Orthopaedic Section.
11. Old Business:
    Jennifer Gamboa reported on the achievement of objectives that were established in 1998:
    - Exploration of performing arts mentorship and fellowship
    - Creation of a membership directory
    - Creation of a marketing brochure
    - Development of a public relations mechanism
12. Unfinished Business:
    - Jennifer opened discussion to the floor on the future

direction of performing arts mentorship and/or fellowship. A summary of this very informative discussion follows:

A consensus was not reached on whether physical therapy for performing artists is a specialty vs. a special interest. This needs to be clarified before a fellowship could be developed. The Orthopaedic Section is encouraging the SIGs to develop fellowships, which are considered "OCS-plus," ie, post-clinical residency training, but is not yet in a position to credential any fellowship program. They will, however, help provide funds to perform a practice analysis of performing arts therapy for the SIG, to aid in precisely defining the content of our clinical practice. This undertaking would not commit the SIG to any future course of action, but would help us determine whether to pursue mentorship or fellowship. Formalizing a fellowship program would in no way diminish recognition of the expertise of Masters in our area of practice, who may not be OCS.

- Motion to conduct a formal practice analysis and to have the Executive Committee comprise a task force that would identify content experts for such an analysis was passed.

13. New Business:
    - Announcement of PASIG participation in the forthcoming "Dancing in the Millennium" Conference in Washington D.C., July 19-23, 2000.
    - A motion was passed to investigate national interstate licensing, which was then referred to the Orthopaedic Section Practice Committee. Any questions regarding this issue should be directed to Jennifer Gamboa.
    - The Universal Screening Tool was tabled.
14. Call for Participation:

    A call was put to the floor for membership participation in 4 key areas:
    - Articles on performing arts physical therapy news from your region; nothing fancy, just tell us what's going on!
    - Announcements for upcoming events for publication in the OPTP PASIG newsletter.
    - Help out at the PASIG booth at the "Dancing in the Millenium" conference. Volunteers are needed for July 19-23 in Washington, D.C.
    - Nick requested contacts for therapists working with symphonies for next year's programming plans. Nick is open to input and suggestions for CSM 2001 programming.

Jennifer invited all attendees to the PASIG reception after the business meeting.

Jeff announced that pins and membership directories were on sale after the meeting. Free sample brochures were available, and brochure orders would be taken.

The meeting was adjourned at 7:45 p.m.

Donna Ritter, PT
Secretary

PASIG Objectives for 2000

Committee	Objectives
Practice Committee Chair: Jennifer Gamboa	• Apply to Ortho Section for funding Practice Analysis • Initiate Practice Analysis • Assist Ortho Section Practice Committee with investigation of national interstate licensing
Mentorship Task Force Chair: Donna Ritter	• Serve as clearinghouse for full/part-time student affiliations and informal performing arts mentorships • Provide routine e-mails to membership re: PASIG news
Education/Programming Committee Chair: Nick Quarrier	• Establish programming for CSM 2001 (consider guest speakers) • Maintain/update PASIG webpage • Develop e-mail list-serve to quickly communicate with PASIG membership
PR and Media Relations Committee Chair: Jeff Stenback	• Maintain/update membership directory • Build library of articles of performing arts physical therapy • Develop quarterly regional news column for PASIG newsletter • Identify vehicles for disseminating articles re: performing arts physical therapy to the general public
Research Committee Chair: Jennifer Gamboa	• Identify participants for Dialogs in Performing Arts Research 2001 • Begin developing network of clinician/university research partnerships
Nominating Committee Chair: Amy Wightman	• Identify candidates for Vice President, Secretary, and Nominating Committee member • Hold Elections for these offices

2000 Strategic Budget Plan

A.	General Expenses (Supplies/Phone)	$ 650.00
B.	Travel Assistance for Executive Board	2000.00
C.	Programming for CSM	500.00
D.	Mailings to PASIG members (Printing/Postage)	255.00
E.	Membership Directory (Printing/Postage)	125.00
F.	Webpage	120.00
G.	Brochure/Press Kit Development	950.00
H.	Membership Pins	400.00
	TOTAL	$5000.00

Jeff Stenback
Treasurer

JOIN THE PASIG FOR DANCING IN THE MILLENNIUM!

July 19-23, 2000
Washington, D.C.

The International Dance Medicine, Arts, Education Conference of the Century!

Sponsored by over 20 dance-related organizations.

The conference will:

- Provide wonderful networking and outreach opportunities for the PASIG on behalf of its membership.
- Provide teaching and learning opportunities for performing arts physical therapists.
- Promote collaboration among dance-related organizations.

People are needed to help out at the PASIG booth and advocate for the PASIG. For more information contact Jennifer Gamboa at: 703-527-9557 or Jenn526@aol.com or contact the website for the conference at: www.artsnet.org/dance2000

PASIG Members!
Advertise yourselves alongside the PASIG!

We now have new PASIG LOGO PINS and BROCHURES to help you advertise and build your performing arts practices. Our directory has been updated and includes state-by-state and alphabetical listing of PASIG members. And don't forget, we still have DANCE/MUSIC GLOSSARIES available.

ORDER NOW!

PASIG PINS	$ 5.00	
PASIG DIRECTORIES	$ 3.00	
PASIG BROCHURES	$15.00	(pkg. of 25)
GLOSSARIES	$ 2.00	

TO ORDER: Call the Orthopaedic Section today at 1-800-444-3982.
All proceeds go to the PASIG.

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Practice Committee Chair:	Jennifer M. Gamboa, MPT see above
Mentorship Task Force Chair:	Donna Ritter, PT see above
Research Committee Chair:	Jennifer M. Gamboa, MPT see above

Pain MANAGEMENT

SPECIAL INTEREST GROUP • ORTHOPAEDIC SECTION, APTA, INC.

Pain SIG Business Meeting Minutes
February 4, 2000, 5:00 – 10:00 PM

Tom Watson, President, called the meeting to order.
Present: 8 members
Observing: Ann Grove, Board Liaison Orthopaedic Section.

The 1999 annual Pain SIG business meeting minutes, made available to the members through *OP*, were summmized and accepted.

OLD BUSINESS:

A) Tom Watson asked members to submit articles to the SIG newsletter in *OP*.
B) Members who wish to become certified in pain management may do so through the American Academy of Pain Management and possibly through the APS in the near future. There will not be sponsorship of certification by the Orthopaedic Section.

NEW BUSINESS:

A) Mary Lu Galatino was thanked again for her well received presentation on Nutrition, Exercise, and Movement in patients with chronic pain.
B) The Preconference course for CSM 2001 program was discussed and the speakers were procured. The course will be "The Paradigm of Physical Therapy and Pain Management in the 21st Century."
C) Home study and weekend courses were discussed, and Tom Watson will be contacting Carolyn Wadsworth about this.
D) The regular CSM 3 hr. course topic ideas are:
    1) Chronic Pain Management for the nonpain management therapist.
    2) Round table discussion with case studies of patients with pain (CRPS, headaches, myofascial pain, HIV/cancer pain). A presenter will do a presentation and case studies will be discussed in smaller groups. Mary Lou Galantino will get input from the Oncology Section. Joe Kleinkort will contact other sections for joint programming.
E) A 3-day workshop was discussed for the year 2002.
F) ELECTIONS: The position of Vice President is to be elected. Joe Kleinkort was nominated by Tom Watson, who temporarily relinquished his duties as president, and seconded by Russell Foley. There were no other nominations. Joe was elected by proclamation.

The meeting was adjourned at 5:59 PM.

John E. Garzione
Secretary

Alternative Approaches to Pain and Healing
By Tom Watson, PT, MEd, FAAPM, President

Traditional approaches to pain management have included pain medication, therapeutic exercises, physical therapy modalities (including ultrasound, electricity, heat, or cold) Swedish massage, mobilization, and other forms of manual therapy. The majority of these interventions have been used for less than 100 years. We really do not understand how any of our interventions truly heal the body. In the rapid changing arena of emergency medicine, cancer intervention, cardiac restoration, organ transplants, and even extremity/limb transplants, there seems to be an acceptance by the general population regarding the new advances in emergency medicine. But there exists a void—the treatment of chronic pain and other chronic conditions. As it turns out, we really do not have a good handle on pain treatment/management.

Alternative Healing by Mark Kastner, L.ACDipl.Ac (La Mesa Calif: Halcyon Publishing, 1993) lists more than 150 alternative approaches to maintaining good health and reducing the pain problem. These areas include acupuncture, bee venom therapy, chelation therapy, cross friction massage, HellerWork, magnetic therapy, movement therapy, myofascial release therapy, physical therapy, trigger point therapy, and yoga. Although I do not agree with many of these alternative approaches, many involve a direct hands on approach to restoring movement and reducing pain. These approaches have been used for hundreds of years and have a place in ancient folklore as well as modern medicine.

The San Diego Union Tribune, June 2, 1999, reported that in 1997, 33.8% of the population sought alternative therapy and 42.1% of the population sought alternative therapy. In 1997, that equates to nearly 386 million visits to a primary care physician and nearly 629 million visits to an alternative medicine practitioner. In 1969 there were 15

massage schools in the United States. In 1998 there were over 800 massage schools in United States. In 1997 there was $21.2 billion spent on alternative medical care in United States. Most common or treated conditions included back and neck problems, fatigue, headaches, strains or sprains, and insomnia. The therapies that increased the most included herbal medicine, mega-vitamins, massage, folk remedies, energy healing, and homeopathy. In 1997, $310 million was spent on echinacea, $270 million on ginseng, $240 million on ginko biloba, and $200 million on St John's wort. How much more was spent in 1999 is yet to be seen, and I'm sure it's significantly more. Many of these supplements and alternative approaches have never been subjected to the scientific scrutiny that our medical providers and schools insist on; however, the general populace takes advantage of the folklore and mystical vitamins that have been used for centuries.

As a physical therapist, I feel it is very important to be "aware" of these alternatives and how much credibility the public places in them by using them. There is now research coming out from the FDA and other reliable sources on the use of different nutritional supplements. Search the newspapers and other professional literature to find these. The FDA has done studies on ginko biloba and shown it to be effective in treating patients with Alzheimers. We also know that chicken soup is what mothers used when we were sick. Is it wrong to use this when you have a bad cold and there's no significant proof that it helps nor does it do harm?

The key is to educate yourself on what is legitimate, effective or a fraud. But if you stay in the dark ages and pretend that alternative healing approaches do not exist and the only approach is "traditional modern medicine " then you are doing your patients and yourself a great injustice. You do not have to agree with any of the alternatives but you do need to be aware of many of them.

A New Approach to Chronic Pain

Joseph A.Kleinkort PT, MA, PhD

Chronic pain presents in many forms. Two common diagnoses, post-traumatic chronic pain, and cumulative trauma disorders (CTDs) seem very different, yet they may have a common denominator in an underlying pathology of fibrosis (adhesions) and/or inappropriate healing.

Post-traumatic chronic pain is often attributed to excessive adhesions or inappropriate scarring that occurred as a response to the trauma or to the surgical intervention and immobilization that followed. It is not uncommon to have a patient with a compound fracture due to a motor vehicle accident complain of continued pain in spite of a good surgical outcome. Soft tissue techniques are often performed in an attempt to free up the adhesions around the site of trauma or the surgical site. However, in spite of the clinician's effort, pain relief is often elusive, resulting in progressive functional difficulties. Surgical removal or manipulation of adhesions is often the only option offered to the patient as a "last-ditch" effort to relieve the pain.

In another realm, CTDs also cause chronic pain and increasing difficulties with function. Traditionally, CTDs were thought of as an ongoing inflammatory process, aggravated by continued stress from a job or activity. Recent evidence in the literature indicates that that may not be the case. Instead, the problem may be the body's inability to deal with ongoing stress, resulting in inappropriate or excessive adhesions and/or a degenerative state within the tissue. This is often termed "tendinosis" rather than tendinitis, because it appears as degeneration of the tendon, without an inflammatory response.

Extensive research has been done evaluating the role of degeneration in tendinopathies. Dr. Robert Nirschl (1992) described the changes that accompany the degeneration of a tendon. He used the term angiofibroblastic tendinosis. In comparison with a normal tendon, he described a degenerative tendon's fibers as "disrupted by an invasion of fibroblasts and vascular, atypical, granulation-like tissue." It is often devoid of any acute inflammatory cells. Sharon Wahl and Dr. Per Renstrom (1990) discussed the role of fibrosis in the healing of soft tissue injuries, and Dr. William Clancy (1996) identified the presence of palpable fibrotic nodules that often accompanies tendons in the state of degeneration. In addition to their text, Human Tendons (1997), Drs. Laszlo Jozsa and Pekka Kannus have authored many articles discussing tendon degeneration. The challenge that has faced clinicians is how to deal with these degenerative changes with a conservative treatment.

Although Kleinkort (1984) described the use of lasers as highly beneficial in the reduction of inflammatory chronic pain, it was mainly used specifically for localized inflammatory conditions and did not address fibrosis in proximal and distal musculature.

One methodology has emerged in recent years that has been effective for both post-traumatic chronic pain and CTDs. Augmented Soft Tissue Mobilization (ASTM) is aimed at the cause of the problem, the fibrosis, and lack of appropriate healing, rather than just the temporary reduction of pain. This treatment incorporates the use of specially designed instruments that enable clinicians to non-invasively induce a controlled amount of microtrauma to the area of soft tissue dysfunction. In cases of fibrosis, it is theorized that the initiation of inflammation through microtrauma recruits phagocytes and other cells necessary to resorb the excessive fibrosis. Similarly, in degenerative situations, the instruments take the tissue from a degenerative, non-inflammatory state and introduce inflammation to initiate the healing process. In essence, ASTM in conjunction with a stretching and strengthening program assists the body in the resorption and remodeling of soft tissue. This promotes the deposition of collagen in appropriate, functional patterns rather than patterns that interfere with function and contribute to pain.

The ASTM instruments are ergonomically designed handheld devices with an angled edge and a resonant quality. A lubricant is applied to reduce the coefficient of friction and prevent abrasive trauma as the instruments are stroked over the skin during treatment. The instruments enhance a

clinician's ability to locate areas of fibrosis and degeneration, and enable the clinician to cover a larger surface area more efficiently than other soft tissue techniques. The angled edge of the instruments "catches" on areas of fibrosis or degeneration, causing microtrauma and triggering an inflammatory response. The instruments function as an extension of the clinician's hands, helping prevent excessive "wear and tear" on the clinician. They are constructed of a polyurethane material that gives them a resonant capacity allowing the tissue irregularity to be detected by the clinician in the form of an increased vibration. This provides immediate feedback to the patient and clinician by identifying the location and amount of fibrosis. Patient compliance is greatly enhanced because the patient can feel the soft tissue texture changes that occur as treatment progresses, engaging them in the treatment process. The treatment is done in conjunction with a stretching and strengthening program that provides the stimulus for proper alignment of the new tissue.

In most cases, patients receive treatment 2 times a week for 3 to 6 weeks. Typically a patient experiences an increase in soreness to touch, inflammation and/or mild bruising for 24 to 48 hours after treatment, followed by a decrease in pain and an increase in mobility and function. Patients are treated at least two days apart to allow the initial soreness from treatment to subside and allow the body time to heal. Clinicians may incorporate other modalities as indicated. One of the most important and attractive aspects of ASTM treatment is that the patient is encouraged to remain on the job or at their current activity level throughout the treatment process. This encourages the new tissue to adapt to the stresses that will be placed upon it during and following treatment.

Outcomes regarding the effectiveness of ASTM are based on the patient's perception of his/her pain and function. In general, the patient must be back to full function or have significantly improved function and must not experience pain over a 3 on a scale of 0–10 of increasing intensity to be placed in the "Resolution" category. Specific criteria are also incorporated depending on the patient type.

The table below demonstrates ASTM's effectiveness in patients with diagnoses that may represent cumulative trauma disorders or post-traumatic chronic problems that were in existence for at least 7 weeks prior to therapy. The outcomes included were gathered from clinicians across the country who are utilizing ASTM in their clinical practice.

ASTM Outcomes
Chronicity > 7 weeks

Diagnosis	# of Cases	Resolved	Unresolved
Ankle	86	72.1%	27.9%
Carpal tunnel syndrome	181	71.8%	28.2%
CTS Postsurgical	13	61.6%	38.4%
Lateral Epicondylitis	358	70.1%	29.9%
Lower leg	33	78.8%	21.2%
Medial epicondylitis	47	78.7%	21.3%
Patellar tendinitis	14	85.7%	14.3%
Shoulder	96	66.6%	33.4%

The overall results at Lockheed's Ft. Worth plant on the above CTDs has been closer to 90% efficacy, this may in part be due to a more rigorous screening process.

In summary, clinicians who have been frustrated in the treatment of post-traumatic chronic pain and CTDs in the past are obtaining encouraging results by tapping into the body's own mechanisms of healing. Recognizing the pathology that lies behind the clinical presentation of a patient's symptoms is an important first-step to addressing them effectively.

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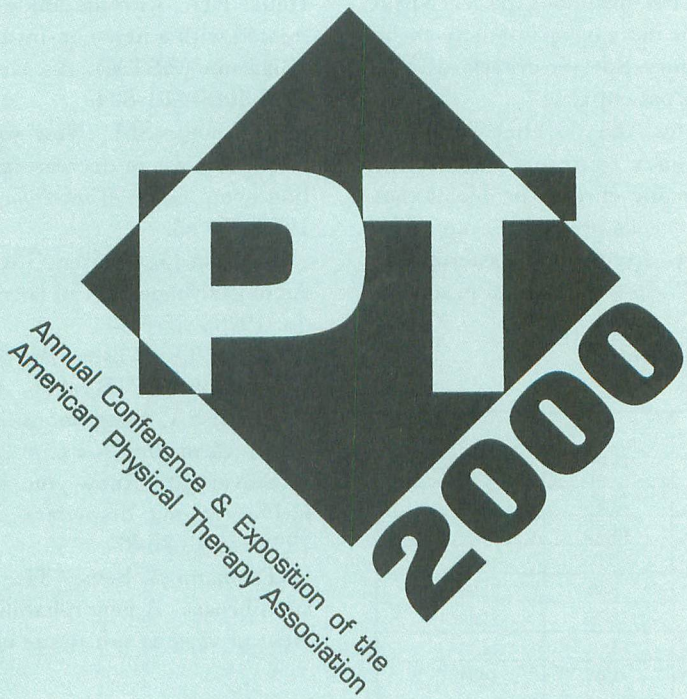

Animal

SPECIAL INTEREST GROUP

Orthopaedic Section, APTA, Inc.

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CALENDAR OF EVENTS

1. The home study course ***Basic Science for Animal Physical Therapists*** is now available. Contact 800-444-3982 for more information.
2. The Animal Physical Therapy Special Interest Group, Orthopaedic Section presents: ***Canine Physical Therapy 1***. The course is offered June 9 –11, 2000 in Knoxville, Tennessee. Call 800-444-3982 for more information.

THE ANIMAL PHYSICAL THERAPY SIG UPDATE

1. Orthopaedic Section Member and Non- member directories are available through the Section Office. As of January 2000, there are 447 Orthopaedic Section SIG members.
2. State Liaisons: To date there are 33 states that have Animal Physical Therapy SIG Liaisons. Contact Rita Brereton for further information.

BUSINESS MEETING MINUTES FROM CSM 2000

The Animal Physical Therapist Special Interest Group (Animal PT SIG) met at the 2000 Combined Sections Meeting (CSM) in New Orleans on Friday February 4. The first election of officers for this SIG was held. Newly elected officers include Cheryl Riegger-Krugh, PT, ScD as President; David Levine, PT, PhD as Vice-President; Nancy Murphy, PT as Treasurer; and Stephanie Fagin, PT as Secretary. Kristinn Heinrichs, PT, PhD, SCS, ATC, CSCS will be the Education Chair. Arlene White, PT continues as Newsletter Coordinator, Rita Brereton, MPT continues as State Liaison, Nancy Snyder, PT continues as Nominating Committee Chair, and Missy Folta, PTA, continues as PTA liaison. Nancy Ford, PT will chair the Clinical Competency Committee. Contact information for the officers, newsletter coordinator, committee chairs, state liaison, and liaisons with the Board of Directors (BoD) for the Orthopaedic Section are included at the beginning of this newsletter. The SIG is grateful to those agreeing to serve and to the sponsorship of the Orthopaedic Section to provide the environment to progress to this point.

The Animal PT SIG expresses immense appreciation to the officers, who have guided the SIG, since the beginning. Special gratitude is expressed to Lin McGonagle MSPT, who has provided wise and tireless leadership for the SIG. Presently, Lin is completing her veterinary technician train-

ing. We look forward to consultation with her in future planning of the SIG. David Levine also provided invaluable leadership in the initial phases for the SIG. Gratitude also goes to Nancy Murphy, Arlene White, Gwynne Oakes, Rita Brereton, Nancy Snyder, Missy Folta, and Cheryl Riegger-Krugh for their past service to the SIG.

There were approximately 23 people in attendance at the meeting, including our Orthopaedic Section BoD Advisor, Nancy White, MS, PT, OCS. Business at the meeting included the following:

1. David Levine, Vice President and Acting President, conducted the elections. David thanked Lin McGonagle for her leadership toward the establishment of the SIG in 1999. Lin has completed a history of the SIG. Dave reported on progress within the SIG in national and international areas. Current membership in the Animal PT SIG is approximately 447 members with 741 non-Orthopaedic Section members interested. Courses related to canine and equine rehabilitation have been very successful and are continuing to be planned. The First International Symposium in Rehabilitation and Physical Therapy in Veterinary Medicine was held in Corvallis, OR in August 1999. PTs and PTAs, veterinarians, veterinary assistants, and a few others were able to exchange information and learn the complexity of each other's disciplines. Dave reported on the educational programs for training for physical therapists in other countries, especially England and The Netherlands. Presently, The World Confederation of Physical Therapists (WCPT) recognizes any area within physical therapy that is also recognized by the professional organization of their country. Each country must have 6 members to become part of the WCPT Animal PT group. By the end of 2000, there will be 5 nations meeting this requirement.
2. Cheryl Riegger-Krugh, Education Chair, reported that the home study course of Basic Science for Animal Physical Therapists is near completion. The set of 3 canine home studies and the set of 3 equine home studies will be distributed January to June 2000 for those participating or later for those applying after January. To date, 297 have requested this home study series. The goal of these home studies is to provide a sound anatomical basis for PTs who want to provide high quality rehabilitation care for animals. Animal anatomy was the most frequently mentioned and initial knowledge base needed by PTs who want to work with animals. CSM 2000 programming was organized through this committee. Lyn Paul Taylor presented "Evaluation and Treatment of the Inflammatory Process in Animals" and Gail Wetzler presented "Integrative Physical Therapy in Animal Health" to 65-75 attendees.
3. Rita Brereton reported that 33 of the 50 states have a liaison to the Animal PT SIG. She is requested information from state liaisons regarding wording in state PT and Veterinary practice acts regarding physical therapists' working with animals. Interpretation of the term "under supervision" would be helpful to include in information sent to Rita.
4. Missy Folta reported that a survey to PTAs is in preparation. She suggested that the database include information regarding each person's credentials.
5. Discussion occurred regarding fees for animal rehabilitation provided by physical therapists. This varies by state. People in attendance discussed a fee for service, a fee for travel for a home visit, purchase of liability insurance if present liability insurance does not cover rehabilitation with animals (and it probably does not) and having the owner sign a consent form. Nancy White stated that physical therapists should be paid directly for services and should not be paid a salary from fees charged by veterinarians. Faculty in academic settings may be covered by their institutions.
6. Goals for the SIG:
   a. Continue to investigate the best path for educational preparation for PTs and PTAs
   b. Develop documentation standards
   c. Develop a public relations information brochure
   d. Develop an information packet for new members
   e. Develop a "how to get started packet" for PTs and PTAs wanting to be involved in animal physical therapy
   f. Compile a compendium of animal rehabilitation/physical therapy literature

While several people volunteered to help with SIG responsibilities, much more assistance is needed and would be welcomed. If you want to assist with SIG duties/projects, please contact Stephanie Fagin.

Submitted by Cheryl Riegger-Krugh

CSM 2001 CALL FOR CASE STUDY REPORTS

The Animal PT SIG is planning to present case study reports at CSM 2001. The goal for the presentations is to acknowledge the effect of intervention for animals. Few clinicians have had the opportunity to assess intervention of a group of animals. Success with one animal may be the clinical basis for pursuing a study with a larger number of animals or the encouragement for clinician to try a particular intervention. We welcome submission of abstracts for this case study session at CSM 2001. All presentations at the Animal Physical Therapist SIG session will be platform presentations. Preference in acceptance will be given to members of the Animal PT SIG and to those on the "List of Individuals Interested in Animal (previously known as Veterinary) Physical Therapy." We encourage poster presentation submissions related to animal physical therapy through the call for participants through the APTA.

General Criteria for Acceptance of all Abstracts

The abstract:

1. Addresses valid and reliability of the content
2. Is interesting to physical therapists and physical therapist assistants

3. Contributes useful knowledge, such as professional direction, insightful point of view, patient care recommendations, cost efficiency of patient care
4. Addresses a current and relevant problem or issue in rehabilitation care for animals

Criteria for Patient Case Reports

1. Purpose, question or problem is clearly stated
2. A clinically relevant description of the patient is included
3. Relevant patient/owner history, evaluation procedures, intervention procedures, results and outcomes are included
4. Terms and concepts are stated in professional language and are defined operationally
5. Discussion/conclusion has clinical relevance

A patient case report abstract should include the following topics with topic headings in bold:

Purpose:
Subject Description:
Owner description (if relevant):
Examination and Evaluation:
Outcome measures used:
Intervention:
Results, including result of outcome measures:
Conclusion:
Clinical Relevance:

Due Date: Abstracts must arrive by October 1, 2000
Submit abstracts to:

Kristinn Heinrichs, PhD,
PT-SCS, ATC, CSCS
P.O. Box 3411
Greensboro, NC 27402

Please alert Kristinn by e-mail that you are sending an abstract and ask for a confirmation of receipt.

Submit an abstract as specified above in hard copy accompanied by the information sheet provided.

Submit the abstract on disc, if possible, with the word processing application (Microsoft Word 7.0, for example) written on the disc with your name and title of abstract) OR submit by electronic submission to: kheinrichs@cstone.net

400 word maximum

Please note correct grammar, use full sentences, and explain any abbreviations, eg, range of motion (ROM).

Clear, dark print with 12-point type

Questions: Kristinn Heinrichs - kheinrichs@cstone.net or 336-574-3184

Complete the Information on this Sheet and submit with your Abstract

Name _____

Credentials _____

APTA Member Number _____

Member of the Animal Physical Therapist SIG? _____

On the List of Individuals Interested in Animal

(Veterinary) Physical Therapy? _____

Address _____

Street, City, State, Zip Code _____

_____

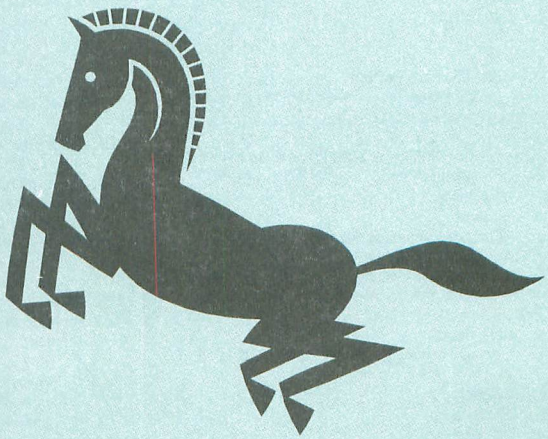
Home Telephone _____

Work Telephone _____

Fax Number _____

E-mail Address _____

At notification of acceptance, you will be informed about the audiovisual equipment available at the session. However, please indicate your preference for audiovisual equipment for your presentation. We will request what you have indicated.



Animal Physical Therapy SIG Membership Survey, 2000

Demographics: Circle or Complete Requested Information

1. Sex.
   a. Female
   b. Male
2. Age. _____ years.
3. State or states in which you practice. _____
4. Entry-level degree.
   a. Associate (PTA)
   b. Baccalaureate
   c. Master
   d. Doctor (please indicate, PhD, ScD, EdD DPT, etc.)
5. Highest degree (please describe). _____
6. Years practicing physical therapy (to nearest full year). _____
7. Years of APTA membership _____
   Years of Orthopaedic Section Membership _____
8. Current physical therapy practice status.
   a. Full-time
   b. Part-time
   c. p.r.n
   d. Unemployed
9. Current practice setting(s) (human patients).
   a. Acute care hospital
   b. Subacute or rehab hospital
   c. Outpatient private practice
   d. Outpatient hospital or corporate owned
   e. Home health
   f. Skilled nursing facility
   g. School
   h. Other (please describe) _____

ANIMAL PHYSICAL THERAPY PRACTICE

10. Which animals are you most interested in treating?
    a. Equine
    b. Canine
    c. Feline (domestic)
    d. Other (please indicate) _____
11. Which of the following best describes your interest in animal physical therapy?
    a. Academic
    b. Treatment of my own, friends', or family's animals (free service)
    c. Part-time practice in veterinary office, clinic, hospital, etc. (fee for service, working for DVM)
    d. Full-time practice as above in c
    e. Part-time private practice, self employed (any setting)
    f. Full-time private practice as above in e
    g. Consultant
    h. Other (please describe)
12. Have you practiced physical therapy or rehabilitation with animals?
    a. Yes
    b. No (you may skip question 14 – 19)
13. Have you received compensation for your animal therapy services?
    a. Yes
    b. No
14. Do you practice only by referral and under the supervision of a licensed veterinarian?
    a. Yes
    b. No (please explain) _____
15. In which of the following settings have you practiced?
    a. Veterinarian's office, clinic, or hospital
    b. Kennel, stable, or boarding facility
    c. Client's home
    d. Own home
    e. Zoo
    f. Farm
    g. Competition
    h. Circus
    i. Shelter
    j. Other (please describe) _____
16. Have you ever been injured while treating an animal?
    a. Yes (please describe) _____
    b. No
17. Please indicate the types of conditions you have treated.
    a. Orthopaedic
    b. Neurologic
    c. Wounds
    d. Pediatric (congenital, developmental, etc.)
    e. Geriatric (arthritis, etc.)
    f. Other (please describe) _____
18. Which physical therapy interventions have you utilized in your treatment of animals?
    a. Ultrasound
    b. Electrical stimulation (NMS, TENS, FES, HVG, IFC, etc.)
    c. Infrared
    d. Ultraviolet
    e. Diathermy
    f. Laser
    g. Manual therapy (includes massage, STM, MFR, joint mobilization/manipulation, CST, PROM, stretching, accupressure, etc.)
    h. Hydrotherapy (whirlpool)
    i. Aquatic therapy (swimming pool, underwater treadmill)
    j. Gait training
    k. Therapeutic exercise
    l. Hot or Cold Packs, baths or wraps
    m. Magnets
    n. Anodyne
    o. Other (please describe) _____

ANIMAL PHYSICAL THERAPY EDUCATION

19. Please indicate how important the following subjects are to your learning about animal physical therapy. 0=not important, 1=somewhat important, 2=important, 3=very important, 4= extremely important, vital to the practice of animal physical therapy.
    a. Anatomy _____
    b. Physiology _____
    c. Biomechanics (osteokinematic, arthrokinematic, etc.) _____
    d. Gait analysis_____
    e. Analysis of movement tasks other than gait_____
    f. Evaluation (ROM, strength, , appearance, skin integrity, posture, deformity, girth, palpation, vital signs, functional limitations and disability, (rather than functional impairments - to be consistent with the disablement/enablement and Guide to PT Practice) other objective observations/measurements) _____
    g. Animal handling skills_____
    h. Pathology_____
    i. Differential diagnosis_____
    j. Electrical modalities (US,ES,IR,UV, etc, excluding laser) _____
    k. Laser_____
    l. Anodyne (nitric oxide mobilization) _____
    m. Thermal modalities (hot or cold packs, baths, wraps, etc.) _____
    n. Magnetic therapy_____
    o. Manual therapy_____
    p. Therapeutic exercise prescription type, progression, protocols, etc. _____
    q. Aquatic therapy_____
    r. Prosthetics/orthotics, assistive devices_____
    s. Wound care_____
    t. Nutrition_____
    u. Neurology_____
    v. Pharmacology_____
    w. Respiratory therapy_____
    x. Animal's occupational/environmental assessment_____
    y. Established practices (referral patterns, forms, procedures, billing, etc.) _____
    z. Marketing_____
    aa. State practices acts, legal issues_____
    bb. Other (please list) _____
20. Which of the following have you used to learn about and develop your animal therapy skills? Please check.
    a. Adapting/modifying human physical therapy to animals
    b. Self-directed study via veterinary or other animal related text books, journals, or periodicals
    c. Mentoring by a physical therapist, veterinarian, veterinarian technician, or other experienced professional
    d. APTA remote site course(s)
    e. APTA home study course(s)
    f. APTA presentation at Combined Sections meetings
    g. Other courses (massage, acupressure, MFR, equine therapy, etc.)
    h. Other learning experience (please describe) _____
21. Of the learning experiences in 20 above, which have you found most valuable or, which do you think would be most valuable in advancing your knowledge and practice of animal physical therapy? If more than 1, please list in order of importance, starting with the most important.
    a. b. c. d. e. f. g. h. (please describe) _____
    i. I believe all the above are equally valuable learning experiences
22. What do you believe the minimum requirements should be for a physical therapist to practice animal physical therapy?
    a. Any licensed physical therapist
    b. A licensed physical therapist who has successfully completed course work in animal anatomy and physiology
    c. A licensed physical therapist who has been mentored by a veterinarian or physical therapist with established credentials in animal physical therapy
    d. A licensed physical therapist who can document a predetermined number of hours working under the direct supervision of a veterinarian
    e. A licensed physical therapist who successfully completes a written exam
    f. A licensed physical therapist who successfully completes some process to be credentialed
    g. Other (please describe, can be any combination of the above) _____
23. What do you believe the minimum requirements should be for a physical therapist assistant to practice animal physical therapy?
    a. Any licensed physical therapist assistant
    b. A licensed physical therapist assistant who has successfully completed course work in animal anatomy and physiology
    c. A licensed physical therapist assistant who has been mentored by a veterinarian or physical therapist with established credentials in animal physical therapy
    d. A licensed physical therapist assistant who can document a predetermined number of hours working under the direct supervision of a veterinarian
    e. A licensed physical therapist assistant who can document a predetermined number of hours working under the direct supervision of a physical therapist with established credentials in animal physical therapy, who is working under the direct supervision of a veterinarian
    f. A licensed physical therapist assistant who successfully completes a written exam
    g. A licensed physical therapist assistant who successfully completes some process to be credentialed
    h. Other (please describe, can be any combination of the above) _____

ANIMAL PHYSICAL THERAPY LEGAL ISSUES

24. Which of the following has jurisdiction over the practice of animal physical therapy by a licensed physical therapist in your state?
    a. Veterinary Board
    b. Physical Therapy Board
    c. Agriculture Board
    d. Other (please indicate) _____
    e. I do not know
    f. It is illegal for a licensed physical therapist without credentials in veterinary medicine (ie, DVM, or certified veterinary technician) to treat animals in my state.
25. Would a lay-person ie, someone without credentials in a health profession be able to establish an animal physical therapy or rehabilitation facility in your state?
    a. Yes
    b. No
    c. I do not know
26. If yes, in 24 above, would this individual:
    a. Be required to employ professionals licensed or certified to treat animals?
    b. Be legally able to treat animals personally?
    c. I do not know
27. Does your physical therapy liability/malpractice insurance policy cover treatment of animal patients?
    a. Yes
    b. No
    c. I do not know
28. If No, in 27 above, is it possible for you to obtain a liability/malpractice policy for the treatment of animals?
    a. Yes – please explain how
    b. No
    c. I do not know
29. If criteria have been established and met for the certification of an animal physical therapist, do you believe there should be a direct access, without veterinarian referral for animal physical therapy?
    a. Yes
    b. No
    c. Undecided
30. If you have any further comments, questions, or concerns about legal or other animal physical therapy issues not covered by this survey, please describe below.

Please send a copy of this survey to David Levine by e-mail, fax, or regular mail:

David Levine, PhD, PT
Department of Physical Therapy
University of Tennessee at Chattanooga
615 McAllie Avenue
Chattanooga, TN 37403
Work: 423-755-5240
Fax: 423-785-2215

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

CALL FOR PARTICIPANTS

MULTISECTION PLATFORM AND POSTER PRESENTATIONS
APTA COMBINED SECTIONS MEETING
San Antonio, Texas
FEBRUARY 14 - 18, 2001

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

DEADLINE FOR RECEIPT OF ABSTRACTS IS FRIDAY, JULY 14, 2000.

CONTENT:
- **RESEARCH** reports must include in order 1) purpose or hypothesis of the study, 2) number and kind of subjects, 3) materials and methods, 4) type(s) of data analysis used, 5) summary data, 6) numerical results of statistical test(s) where appropriate, 7) conclusion, 8) clinical relevance. This category would also include single-subject research designs.
- **SPECIAL INTEREST** reports must present a unique program, idea, or device and must include 1) purpose of the presentation, 2) description, 3) summary of experience or use, and 4) the importance to members of the Section to which the abstract is submitted.
- **CASE STUDIES** must 1) present the treatment of a patient or a series of patients, 2) provide unique insight into the treatment or natural history of conditions seen by physical therapists, and 3) include accurate descriptions of the patients, treatments, and outcomes.
- **THEORY** presentations must 1) state the phenomenon that the theory proposes to explain or predict, 2) explicitly state the theoretical proposition or model, 3) give the evidence on which the theory is based, 4) suggest ways that the theory could be tested, and 5) describe the importance and utility of the theory to members of the Section to which the abstract is submitted.

LIMITATIONS:
- Each prospective presenter may submit ***no more than two*** abstracts total.
- The same abstract may not be submitted to more than one Section.
- The primary (first) author of the abstract ***must be a current member in good standing of the Section to which the abstract is submitted OR must be sponsored by a current member in good standing of the Section to which the abstract is submitted.***
- Each abstract must indicate if the material has been/will be submitted or presented at any other national or international meeting or appear in publication prior to the 2001 Combined Sections Meeting. Some Sections will only consider original material for presentation or may restrict presentations to those that have not yet been available to Section members.
- Some Sections may have other limitations on submitted material. See listing of the individual Section Contacts for details.
- Poster and Platform presenters must be registered for CSM for the day of their presentation.

EVALUATION AND SELECTION:
- All abstracts are reviewed by the Section declared on the Abstract Form, without knowledge of the identity of the authors, by selected member(s) of the Section to which the abstract is submitted. Abstracts are selected on the basis of compliance with the content requirements, logical arrangement, intelligibility, and degree to which the information would be of benefit to the members of the Section. All selections are final.

FORM:
- ***All abstracts must be submitted on the approved*** **Abstract Form**, following the instructions below and the sample on the reverse side of the Abstract Form. The **Abstract Form** may also be photocopied if the photocopy is clean and legible.

NOTIFICATION:
- Notification of acceptance for presentation of abstracts will be made by October 2, 2000.
- If notification concerning presentation of a ***poster*** abstract is not received by October 13, 2000, please contact the Executive Office of the Section on Research (See address and telephone number below).
- If notification concerning presentation of a ***platform*** abstract is not received by October 13, 2000, please contact the Program Chair of the section to which the ***platform*** abstract was originally submitted.
- Notifications will be sent to the address listed on the **Abstract Form**. If the address of the person submitting the abstract changes, it is that person's responsibility to notify the Executive Office of the Section on Research before September 10, 2000.

FORMAT:

All abstracts must be submitted on the approved Abstract Form in the format outlined below:

- No printing may *touch* on, or ***exceed,*** the limits of the Abstract box, nor should printing ***touch*** the lines of the Abstract box. The only other printing that is to appear on the Abstract Form is the required information.
- The print must be clear, dark, elite or pica size (10- or 12-point type), and produced on an electric typewriter, a letter-quality printer (impact or laser), or a high-quality dot-matrix printer with near-letter-quality type. The abstract must use standard abbreviations and should not contain subheadings, figures, tables of data, or information that would identify the authors or the institution.
- Identifying information must be single-spaced inside the Abstract box, beginning just below the top margin of the Abstract box, and must include only 1) the title in all-capitalized letters; 2) the full last name(s) and first and middle initials of the author(s), with the presenter's name underlined; 3) the institution/facility where the work was done; 4) the city and state of the institution/facility where the work was done; 5) acknowledgment of any financial support for the work being presented. ***Do not*** add headings, such as *Title, Author, Address,* etc, for the identifying information printed at the top of the Abstract box.
- The body of the abstract must be ***single-spaced.*** Section headings, such as *Purpose, Methods, Data,* etc, should appear in a different typeface, such as **bold** or *italic.* The Section headings may be within a line of text, or they may start a new line.
- ***All*** information on the Abstract Form must be provided in machine-printed format (no hand-printed information, please).

COPIES:

For ***each separate abstract*** submitted, please provide, ***in the following order***:

- Two (2) copies of the completed Abstract Form with all identifying information on the Abstract Form and at the top of the Abstract box.
- Five (5) copies of the abstract with ONLY the title and the body of the text (eliminate all identifying information except the title within the Abstract box). ***Do not*** complete the identifying information on the Abstract Form for these five (5) copies.
- Paper-clip ***(do not staple)*** all seven (7) pages together if more than one abstract is enclosed in a mailing.
- ***No*** fax, e-mail, or other electronically transmitted submissions will be accepted. ***Do not*** fold. Mail flat.

- Mail all submissions to:

CSM Abstract Submission
c/o APTA NJ - Section on Research
1100 US Highway 130, Suite 3
Robbinsville, NJ 08691-1108
609/208-1116

- Address questions to:

Scott D Minor, PhD, PT
314/286-1432 (voice)
314/286-1410 (fax)
minors@medicine.wustl.edu

All submissions must be received in the Executive Office by the end of the business day on July 14, 2000. Submissions delayed or sent to individual Section offices and received after the deadline will not be accepted.

SECTION CONTACTS

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Platforms-Graduate student research only
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Limitations: Original Material Only
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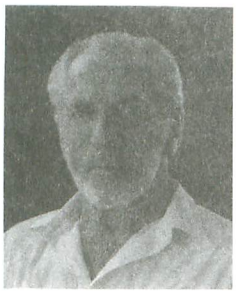

Olaf Evjenth
2000 U.S. Continuing Education Course Schedule

Date	Course	Price
May 31 - June 4	**Advanced Clinical Problem Solving of Spinal Disorders** *Days of attendance with price modification available.*	$700.00
June 5 Rochester MI	**A Day In The Clinic With Olaf Evjenth** Contact: John Krauss 248-370-4044 Oakland University Program in Physical Therapy Rochester MI 48309 Krauss.@oakland.edu	$130.00
June 10 - 11 Boston MA	**Manual Therapy Update with Olaf Evjenth** Contact: Martin Langaas or Debbie Dion 781-229-9353 Institute of Orthopaedic Manual Therapy Burlington MA 01803 www.capeonramp.com/iomt	$350.00
June 17 - 18 Los Angeles CA	**Management of the Patient with Lumbar Dysfunctions** Contact: Kornelia Kulig 323-442-2911 University of Southern California 1540 E Alcazar St CHP-155 Los Angeles CA 90033	$300.00
June 22 - 25 Folsom CA	**The Cervical Spine with Olaf Evjenth: *Evaluation and Treatment in the Arena of Managed Care*** Contact: Emily Moore 916-985-3115 Michael J Moore Seminars 115 Natoma St Folsom CA 95630	$600.00

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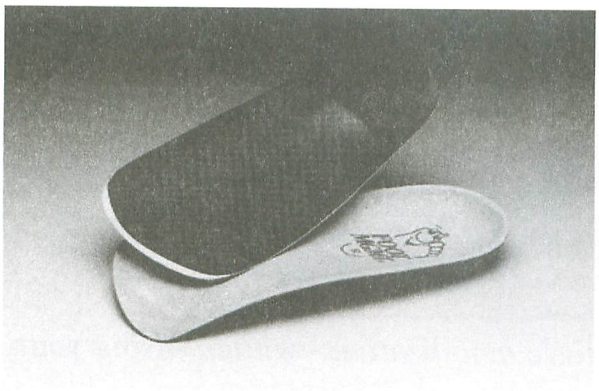

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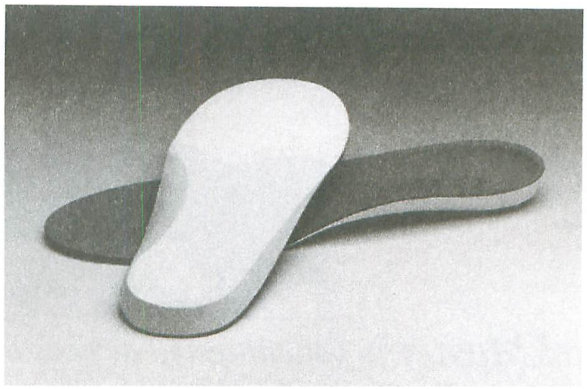

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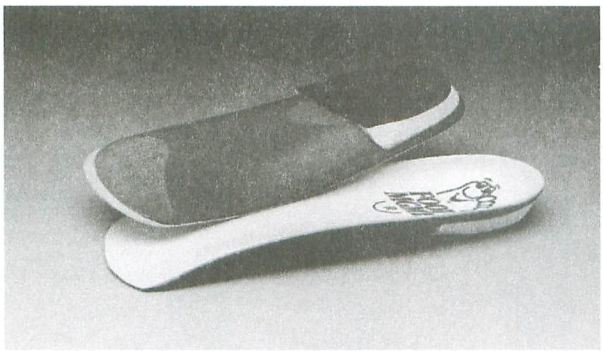

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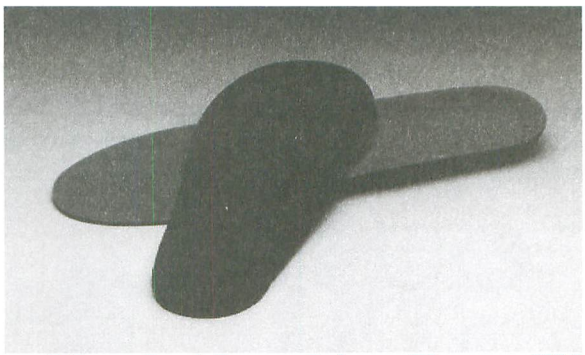

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