

ORTHOPAEDIC

PHYSICAL THERAPY PRACTICE

THE MAGAZINE OF
THE ORTHOPAEDIC SECTION, APTA

VOL. 12, NO. 4

2000





The Institute of Physical Art

Preliminary 2001 Schedule of Courses

FO I: An Integrated Manual Therapy System - 3 1/2 Days, 30 Contact Hours (\$525)

The foundation of Functional Mobilization™, Functional Orthopedics I presents a systematic manual therapy approach for the treatment of musculoskeletal dysfunction and pain, with emphasis on soft tissue mobilization. The cutting edge aspect of FO I is the integration of STM with PNF, joint mobilization, body mechanics training and rehabilitative exercise programs. This approach emphasizes the enhancement of function as an avenue to effective and efficient treatment of mechanical symptomatology.

January 18 - 21	Jacksonville, FL	March 29 - April 1 ...	Lake Forest (Chicago), IL	September 20 - 23	San Francisco, CA
January 25 - 28	Long Beach, CA	May 3 - 6	Minneapolis, MN	September 20 - 23	Reading, PA
February 8 - 11	Phoenix, AZ	May 3 - 6	New York, NY	October 11 - 14	Pomona, CA
February 22 - 25	Baltimore, MD	May 17 - 20	Puyallup (Tacoma), WA	October 18 - 21	Jacksonville, FL
March 7 - 11	Steamboat Springs, CO	June 7 - 10	Atlanta, GA	October 25 - 28	Denver, CO
March 8 - 11	Birmingham, AL	July 26 - 29	Colorado Springs, CO	November 1 - 4	Charleston, WV
March 15 - 18	Fremont, CA	July 26 - 29	Milwaukee, WI	November 5 - 8 (M-Th)	Bay Shore, NY
March 22 - 25	Patchogue, NY	August 2 - 5	Alexandria, VA		

FO II: Functional Orthopedics II - 3 1/2 Days, 31 Contact Hours (\$550)

Under the instruction of Gregory S. Johnson, PT, FFCFMT, the participant learns to identify and treat soft tissue and joint dysfunctions through integrated mobilization techniques and utilization of Functional Movement Patterns™. Skills and procedures learned are effective for the treatment of the symptomatic as well as contributory dysfunctions which affect the balance and motion of the entire kinetic chain.

Prerequisite: FO I and any basic mobilization course.

April 5 - 8	Atlanta, GA	July 12 - 15	San Francisco, CA	November 1 - 4	New York, NY
May 31 - June 3	Denver, CO				

FM LQ & UQ: Functional Mobilization™ Lower & Upper Quadrants - 3 1/2 Days, 32-34 Contact Hours (\$550)

A unique advanced, systematic approach developed and taught by Gregory S. Johnson, PT, FFCFMT, Functional Mobilization trains the therapist in a systematic integration of soft tissue and joint mobilization with the dynamic principles and procedures of PNF for mobilization, stabilization and neuromuscular reeducation. The emphasis is on the integration of the tools of PNF I and FO I to assess the interrelationships of the kinetic chain and the neuromuscular system. This approach presents concise strategies for the evaluation of each movement segment for its mechanical condition and neuromuscular control. The participant is trained to evaluate each movement segment through the use of PNF patterns and to combine the selective pattern into the full trunk and extremity patterns. Prerequisites: FO I & PNF I or Kaiser Vallejo Program.

LQ-March 1 - 4	Thousand Oaks, CA	LQ-May 3 - 6	Alexandria, VA	UQ-October 4 - 7	Fremont, CA
UQ-March 15 - 18	Algonquin (Chicago), IL	UQ-September 13 - 16	Charlotte, NC		

BET: Back Education and Training - 2 1/2 Days, 20 Contact Hours (\$425)

Active Functional Rehabilitation which offers more than just stabilization by teaching self responsibility through five foundational principles of efficient posture and movement. The course includes five two-hour dynamic exercise training sessions.

February 9 - 11	San Francisco, CA	June 22 - 24	Patchogue, NY	October 12 - 14	Baltimore, MD
February 23 - 25	Milwaukee, WI	June 29 - July 1	Boulder, CO	October 19 - 21	Milwaukee, WI
March 23 - 25	New York, NY	July 27 - 29	Beverly (Boston), MA	November 2 - 4	Phoenix, AZ
April 20 - 22	Jacksonville, FL	September 14 - 16	Long Beach, CA	November 16 - 18	Atlanta, GA
June 22 - 24	Charlottesville, VA	September 21 - 23	Lockport, IL		

PNF I: A Manual Neuromuscular Treatment System - 3 1/2 Days, 28 Contact Hours (\$525)

The Functional Approach to PNF, offering a dynamic manual evaluation and treatment approach based on specific analysis of motor recruitment patterns. This approach bridges the skills utilized for orthopedic and neurological care into a compact approach of functional enhancement.

January 25 - 28	Staten Island, NY	April 26 - 29	Beverly (Boston), MA	September 13 - 16	Atlanta, GA
February 8 - 11	Colorado Springs, CO	April 26 - 29	Chicago, IL	September 13 - 16	Puyallup (Tacoma), WA
February 8 - 11	Mobile, AL	May 17 - 20	Milwaukee, WI	September 13 - 16	Patchogue, NY
February 22 - 25	Ft. Lauderdale, FL	May 17 - 20	San Francisco, CA	September 20 - 23	Chico, CA
February 22 - 25	Jackson, MS	June 7 - 10	La Jolla, CA	September 20 - 23	Denver, CO
March 8 - 11	Winchester, VA	July 12 - 15	St. Augustine, FL	October 25 - 28	Libertyville (Chicago), IL
March 15 - 18	Milwaukee, WI	July 19 - 22	Alexandria, VA	November 1 - 4	Long Beach, CA
March 22 - 25	Pomona (LA), CA	August 9 - 12	Miami, FL	November 8 - 11	Baltimore, MD
March 29 - April 1	Charlotte, NC				

CFMT™: Certified Functional Manual Therapist - 6 Days. (\$795)

A review and testing of material from eight courses: BET, PNF I, FO I, FO II, FM: LQ & UQ, CTI and LPI.

August 6 - 11

IOC: Integrated Orthopedic Certification - (\$750)

In collaboration with Stanley V. Paris, PhD, PT, and the Institute of Physical Therapy (IPT), this joint certification offers a review and testing of material from four IPA courses: BET, PNF I, FO I, FO II, and two IPT courses: S-1 and E-1. August 6 - 11 Steamboat Springs, CO

Dates and locations may change!!

Consult our web page for complete course information and the latest updated schedule.

IPA, Inc., 43449 Elk Run, Steamboat Springs, CO 80487 970-870-9521 • www.ipaconed.com

Thank you!

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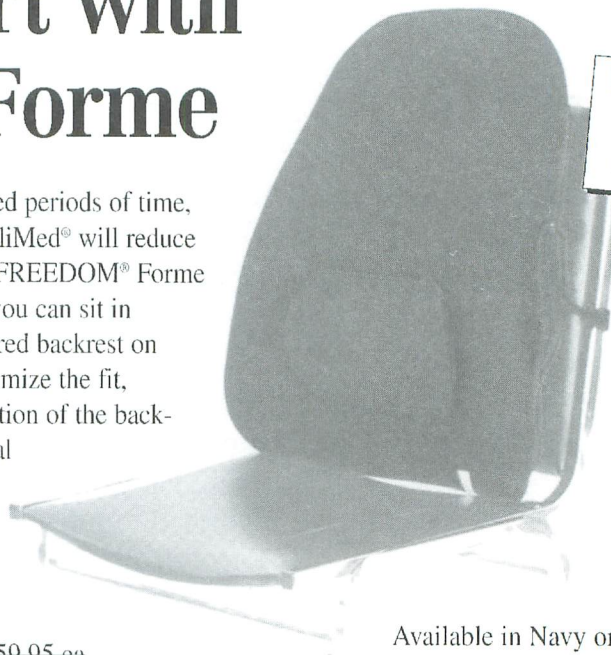
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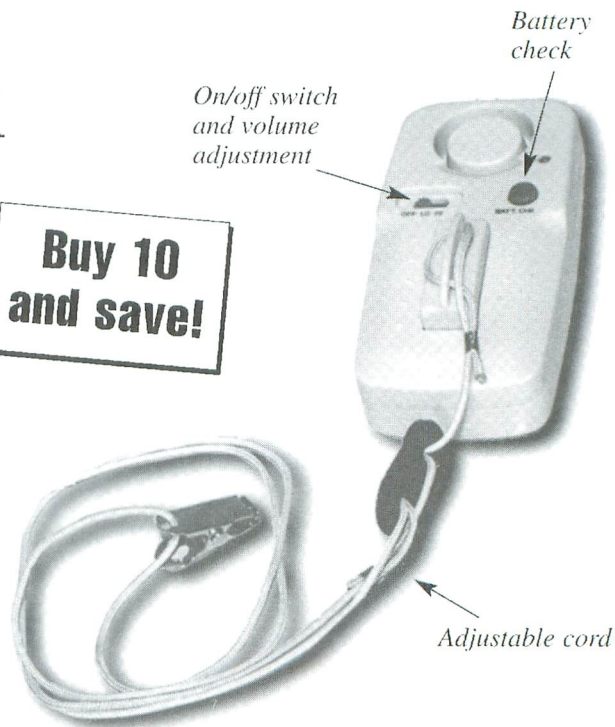
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The mission of Orthopaedic Section of the American Physical Therapy Association is to be the leading advocate and resource for the practice of orthopaedic physical therapy. The Section will serve its members by fostering high quality patient care and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

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

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<p><i>Terri DeFlorian, Executive Director</i> x 204 <i>tdflorian@centurytel.net</i></p> <p><i>Tara Fredrickson, Executive Assistant</i> x 203 <i>tfred@centurytel.net</i></p> <p><i>Sharon Klinski, Managing Editor</i> x 202 <i>sklinski@centurytel.net</i></p> <p><i>Kathy Olson, HSC Coordinator</i> x 213 <i>kmolson@centurytel.net</i></p>	<p><i>Stefanie Snyder, Program Coordinator</i> x 205 <i>ssnyder@centurytel.net</i></p> <p><i>Linda Toedter, Project Assistant</i> x 215 <i>ltoedter@centurytel.net</i></p> <p><i>Jessica Gandy, Receptionist</i> x 201 <i>jpgandy@centurytel.net</i></p>		



Editor's Message



"To Everything, Turn, Turn, Turn"

This time of year always gets me in a mood of reflection. I am not sure if it is the changing of the leaves, the anticipation of the holidays, or just the marking of the end of one year and the beginning of the next. For me, it is a time to reflect on what is past and anticipate what will be in the future. This season provides us an opportunity to consider where we are in our own lives and in our profession. Let us now consider where we have been in the past year.

We started out the year in New Orleans with a record number of physical therapists, physical therapist assistants, and PT and PTA students coming together to learn and to celebrate. There was discussion of a vision and debate continued about the DPT. The Section officers and Board of Directors continued their work relative to the mission and vision of the Section. There were many opportunities for PTs and PTAs to interact with others with the same special interests. There also were opportunities to celebrate, including the annual recognition ceremony of newly certified specialists, and recognition of Section award winners. What did we learn in N'awlins? PTs and PTAs love CSM—we need more space; people are passionate about their own perspectives of a vision for the profession; and who really needs Mardi Gras when CSM is in town!

Later, we were in Indianapolis, where the House of Delegates made many decisions affecting the future of our profession. After much debate, the delegates endorsed "Vision 2020." Some believe it is a bold statement about our future, while others believe it is not so bold, but where we have already begun to go. Regardless, Vision 2020 is now our guiding light. It is directional regarding entry-level practice. Whether it be a "clinical designator" or entry-level degree, the DPT is where we are definitely headed. An increasing number of educational institutions are moving to the DPT entry-level, while many others consider it. Even more importantly, this vision makes clear our intent to practice autonomously. The ever-changing health care environment will have to be guided, at least in part, by us for autonomous practice to become a reality. What did we

learn in Indy? Patience is a virtue; majority rules; education, education, education; and an environment of mutual respect and cooperation is required if we are to survive and thrive in the future.

In October, the Orthopaedic Section Officers, Board of Directors, Committee Chairs, and SIG Presidents met in La Crosse for a strategic planning session.

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Although it was a long day, the mission and vision of the Section became clearer to me as we defined our goals and objectives for the next 3 years. These goals and objectives will guide the officers of the Section in decision making regarding how and when time, energy, and financial resources will be spent. We also celebrated. We found out that, unlike APTA and many components, our membership increased last year. It is through the efforts of each individual Section member that we grow. Keep up the good work! We also recognized the efforts of the Section office staff. Without them, we would not be where we are today! What did we learn from this experience? Knowing your destination is required in order to get there; there are many routes to the same location; actions speak louder than words; and even the softest of chairs gets hard after 8 or 10 hours.

Now, what about the future? The year 2001 marks the final year that physical therapists will graduate from bachelor's degree programs. What impact will this truly have on practice? What about the physical therapy job market, supply and demand issues, and the health care environment? Will reimbursement be the

primary force that drives practice? What is our best route to "physician status" under Medicare? When will we achieve autonomous practice? How can we best teach our students to become the type of practitioner that we believe is necessary in an autonomous practice environment? These are not easy questions to answer. But we must continue to search and find answers. It will require each of us to set aside personal preferences and look to the greater good of our profession. Vision 2020 gives us a destination, but we must create the map to get us there. The events of the year 2000 have set us on our way.

In this issue of *OP*, Gordon Browne has provided us with an insightful article about the importance of motor learning and motor control in orthopaedic physical therapy. Jean Bryan has written an article to further explain the recent changes in specialist certification requirements. Carolyn Bloom's article describes the peer review process and offers suggestions to get started as a claims reviewer. Gary Shankman gives us an informative article on forearm fracture and rehabilitation.

In addition to our feature articles, this issue also includes the "Practice Affairs Corner," which I highly recommend you read—especially if you anticipate legislative issues that will require you to defend manual therapy as a part of your practice. The SIG newsletters are full of information about what's been going on since Annual Conference and about what is coming up for CSM. Each group has some exciting plans for CSM in San Antonio. There is also a list of poster and platform presentations, as well as a tentative schedule for the events at CSM.

Have a safe and happy holiday season. Enjoy your family, friends, and clients. Begin the New Year of the third millennium with peace of heart and mind and with kindness in your soul.



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

President's Message

Building Bridges

Where has the time gone? This President's Message is my 22nd and final message as President of the Orthopaedic Section. None of the previous messages have been particularly easy to write, but this one is especially challenging. Where do I start? How do I finish? How can I adequately express my appreciation to all of you who have been so supportive to me personally, and to the Section since 1995? I am still not quite sure as I sit down to write this, but the deadline for this message was yesterday so here we go!

As with my predecessors (and I am sure my successor), I harbored a vision for the Orthopaedic Section when I assumed this position. I accepted the responsibilities of being the President fully aware of the storied history of the Section and its tremendous accomplishments since 1974. I also was aware that some of the aspirations of the Section's founders had not yet been fully realized. To finish some of the original tasks and to successfully complete new initiatives, I believed the Section needed to expand its role as being THE leading advocate for Orthopaedic Physical Therapists and for Orthopaedic Physical Therapy practice. Thanks to my predecessors, the Section was resource-rich when I began my first term (I am relieved to say that even with all the resources, including money, we have used the past 5.5 years we are still financially solvent and secure). We had the resources, but without the commitment from members and our office staff who were willing to invest valuable time on behalf of the organization, progress would not have been made on any front. I am most proud of the fact that we have had so many members step forward and contribute to the Section. The final necessary piece for the *advocate* role that I so strongly believed in was for the Section to build new bridges and strengthen existing ones.

A bridge of any type allows for the flow of traffic (communication) and resources to occur with much greater efficiency and effectiveness. A bridge CONNECTS one group to another and the stronger the connection, or the more bridges that are built, the chances of a successful outcome are greatly enhanced. A challenge in 1995 was to strengthen our two most important bridges, the one connecting the Section with membership and the other connecting the Section Board of Directors (BOD) with the office staff. I believe developing

the Mission and Vision and the strategic plan in 1997 was a most important step in connecting the Section as an organization to the membership. Priorities were now set in terms of how to allocate our valuable resources. At our recent Fall BOD Meeting, Dr. Jody Gandy of APTA staff once again led us through our second long-range strategic planning meeting. As we did before, the proposed plan will be presented to membership at CSM 2001. Once again your feedback will be crucial as to how the Section allocates its resources. Strengthening the bridge between the Section BOD and the office staff is an ongoing challenge. Due to the nature of our organization, the Section office staff rarely sees the BOD and vice-versa. Because of this, extra effort on everybody's part is essential to develop the strong link that is absolutely necessary in order for business to be carried out effectively. Subsequently, we made the decision to hold the Fall BOD Meeting in our beautiful office building located in LaCrosse, WI every other year. In addition, we just recently made the decision to have the newly elected President and Vice President fly to LaCrosse for an orientation day so they can meet with staff and begin to understand the functions that take place at our office. We will also develop a teleconference orientation module for newly appointed committee chairs and members, and new Special Interest Group officers so a quicker understanding related to how our organizational structure is set up and how it functions occurs.

We have made a concerted effort to strengthen our relationship with APTA and other components. In fact, we have committed to holding our Fall BOD Meeting at APTA in Alexandria, VA on the *off-years* when we are not meeting in LaCrosse. We cannot afford to waste valuable resources by *reinventing wheels*. We cannot afford to have Components being unaware of resources which are available and that are designed to assist them with legislative challenges. We cannot afford to have APTA be unaware of the needs and concerns of our membership and conversely, we cannot afford to be ignorant of the priorities being set at APTA and at the Chapter level. The increased level of communication that has taken place between the Section and APTA and the Chapters has led to collaborative efforts that have benefited the entire profession. Our efforts have led to gains being made in the areas of practice, education, and research.

The priority of protecting our right to practice as it is described in the *Guide to PT Practice* has led to the development of the Manual Therapy Legislative Compendium, and to the creation of the Task Force for the Development of a Manual Therapy Legislative Strategic Plan. This task force, a joint effort between the Orthopaedic Section, the APTA, and the AAOMPT, has developed a series of short- and long-range objectives, some of which have already been completed. An important by-product of the Task Force's initiatives has been the collaboration that has developed with other components. For example, Trish King and I just recently spoke to the Academic Administrators SIG of the Education Section regarding the topic of joint manipulation and physical therapy professional education, and at the House of Delegates 2000, every Section present co-sponsored the RC describing the delegation of joint mobilization/manipulation. Our hope all along has been that the manual therapy initiative, if successful, would become a template for how to tackle other national legislative issues. The initial results of our efforts are very encouraging, and the collective response we have received from all interested parties has been extremely positive.

In the area of education, we remain committed to the role of specialist training. This is one of the areas where I don't believe our Founders' vision has yet been fulfilled. Looking ahead to 2020, we are debating how to best train doctors of physical therapy. We seem to be ignoring what the other health professions have learned decades ago—that clinical residency and fellowship training are essential elements for the development of specialists. Yes, we have a specialist certification process, but there is still significant debate and disagreement over what the term clinical specialist should imply. Yes, we do have a few clinical residency programs; but at the rate we are developing them, it may be 50 years before we have a residency program located in each state. How much longer can we wait for our profession to agree upon a complete continuum of professional and postprofessional training? I believe we have a window of opportunity available to us right now, if we ready. Our professional education programs are moving towards the training of doctors of physical therapy. This was occurring before the House of Delegates passed the Vision 2020 Statement, which included the

"D" word. Since we are exploring how to best train doctors of physical therapy, let us revisit our specialization process. Can we link clinical residency education, including fellowships to our professional education process? I believe the mentoring which occurs in a clinical residency setting is vital to the development of the level of clinical decision-making skills required of doctors of physical therapy. Can we link clinical specialist examinations to clinical residency and fellowship education as a way to designate who our specialists are? Now is the time for us to consider these questions and others as we explore doctor of physical therapy education.

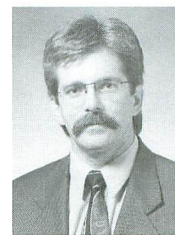
Our primary contribution to research has been through the provision of dollars to support our research experts and through the continued commitment to JOSPT. The Orthopaedic Section has been fortunate to have the ability to make significant contributions to the Foundation for Physical Therapy (FPT) and to support our own small grant program. We are all aware of the need for scientific evidence related to physical therapy practice and the push for evidence-based practice. The money we have contributed is an investment to our future. The large sums (by our profession's standards) we have contributed will not come close to meeting the *lack of evidence crisis*, but we have planted some seeds. This support must continue if we are to continue practicing, as we would like to practice. The chal-

lenge to our research community and the FPT is to continue developing the appropriate vehicles which can produce the type of research we need. When these vehicles are in place, the Orthopaedic Section should be the largest supporter of orthopaedic physical therapy research if we truly are to be THE advocate for the Orthopaedic Physical Therapist. Our commitment to JOSPT as a joint effort with the Sports Section remains strong. It is our primary vehicle used to disseminate scientific literature to our membership and to others and the Journal's reputation as a respected scientific publication continues to grow. I believe it is important to continue developing strong ties with the Sports Section as we work to further enhance JOSPT.

As an organization we have made progress since 1995 but in many ways the Section has simply laid a few more building blocks upon which further growth can occur. The challenges facing Orthopaedic Physical Therapists will continue to present themselves. The group effort must continue on behalf of the Section in order for the success to continue. The building of new bridges must continue while the nurturing of existing bridges continues. Linking with groups outside our profession will take on increased importance as we face the next rash of health care changes. One example may be establishing dialogue with the Chiropractic Associations. Dr. Stanley Paris recently proposed this at Annual Confer-

ence in Indianapolis. Can we find some common ground with our long-time legislative adversary? General dialogue with the Chiropractic Associations may be the first step towards reconciling our differences. How nice would it be if we could begin spending time and energy on issues other than encroachment from this group?

Serving the Orthopaedic Section as President has been the most rewarding professional experience I have ever had. I will be forever grateful for the opportunity you have given me. I am indebted to the officers, committee chairs, and members and the SIG officers that I have been so fortunate to work with. I cannot thank the office staff enough for their support from day 1. I mentioned in a previous President's Message how honored I was to have my picture taken with the past-presidents of the Section at our 25th Anniversary celebration. After the next CSM I will be just as honored to have my name included on the list of past presidents of the Orthopaedic Section. Thank you and I hope to see you in San Antonio at CSM 2001!



William G. Boissonnault,
PT, MS, DPT
President

Orthopaedic Section, APTA, Inc. 2001 - 2004 Goals

The first day of the Fall Board of Directors Meeting in La Crosse was spent updating our strategic plan. We re-examined the Section's Mission and Vision statements, as well as the current goals, objectives, and strategies. The Mission and Vision were deemed appropriate, so we focused our energy on first the goals, and then the objectives. The following is a list of goals identified by the BOD. Please review them and send us your feedback. We are currently working on refining them, as well as refining the objectives and strategies. This will be presented formally at the Section Business Meeting at CSM in San Antonio on Saturday morning and will be the basis for our discussion. Your feedback is important to further clarify our goals and objectives as a Section. Thanks in advance for your efforts!

GOAL #1

Facilitate continued professional development in orthopaedic physical therapy clinical practice.

GOAL #2

Create dynamic leadership development programs for members.

GOAL #3

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

GOAL #4

Promote knowledge of and provide support for physical therapists as an entry point in the classification and management of musculoskeletal dysfunction.

GOAL #5

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

GOAL #6

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

GOAL #7

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

GOAL #8

Maintain current membership growth rate of 2%.

Strengthening Exercises: A Motor Learning Perspective

Gordon Browne, PT

INTRODUCTION

As physical therapists, we use motor learning concepts with our patients all the time. Postural and ergonomics instructions are obvious examples. Body mechanics instruction, gait training, balance training, and relaxation techniques are further examples of motor learning applied in a clinical setting. Joint instabilities require muscular and sensory retraining to recognize and check it when too much movement occurs. Manual therapy and the various bodywork methods that seek to gain collagen mobility in joint or fascia need motor control over that new range or direction of movement. Some muscles need to learn to lengthen into an unfamiliar range while others have to learn to contract into that same unfamiliar range. The central nervous system (CNS) has to change habitual firing patterns of motor neuron inhibition and excitation. Though a manual technique may *allow* more movement somewhere, it does not *necessitate* it. Motor learning comes in here when we want our patients to functionalize that newly available movement into intentional action and common, daily activities.

We might not think of therapeutic exercise as being a motor learning technique, but we already often use it that way. Much of our rationale for prescribing exercises is essentially motor learning; we want our patient to move “better” in order to improve function and *reduce tissue strain or damage*. We already use exercise to change behavior—arthrokinematic, postural, and gross motor behavior. We strengthen the rotator cuff muscles to control glenohumeral arthokinematics and the vastus medialis to better track the patella. We stretch the pectoralis major in people who protract their shoulder girdles and stretch the iliopsoas in our patients who hyper-extended their low backs. These types of exercises are designed to improve either existing but inefficient movement and postural patterns, or injury-induced abnormal patterns. The remainder of this article focuses on how we might expand our rationale regarding traditional therapeutic exercise, using motor learning concepts to make strengthening exercises more effective.

QUALITATIVE AND QUANTITATIVE STRENGTHENING

We know how to make a muscle stronger. We can stimulate recruitment

of more muscle fibers and improve its efficiency. We can increase the size of the muscle fibers and the mass of the muscle as a whole. We can measure the torque produced by a particular muscle and graph where in its range it is the strongest. This is quantitative strengthening, objective and measurable. When quantitatively strengthening the gluteus maximus, for instance, it doesn't matter what the orientation to gravity is, whether the foot is on or off the floor, what the synergists are doing, whether the antagonists are adequately inhibited, or whether the contraction moves the thigh on the pelvis or pelvis on the thigh; it is enough to have a muscle simply produce more force. From a motor learning perspective, however, qualitative strengthening is a more important clinical goal.

Qualitative strengthening is about the smooth recruitment of just enough motor units to get the job done—economy of effort. It is about firing those motor units only when needed and stopping the contraction when it's no longer needed—timing and coordination. It includes the accurate and simultaneous inhibition of antagonists and the cooperation of appropriate synergists in function-specific whole-body patterns; it is integrative rather than isolationary. Qualitative strengthening requires a sense of purpose and an active kinesthetic awareness on the part of the patient in order to make informed decisions on how and when to apply that strength. In terms of practical clinical usefulness, perhaps the main characteristics of qualitative strengthening are patient self-awareness, pattern specificity, and functional context.

PATIENT SELF-AWARENESS

The need for paying attention to kinesthetic sensations when learning a motor skill seems obvious. When hitting a tee shot in golf, for instance, I want to know what kinesthetic sensations are produced. If I know and can reproduce the feeling in my legs, pelvis, chest, arms, head, and eyes when I hit the ball, I have a great tool for improving my game. Knowing and reproducing the kinesthetic sensations created by a ball well hit is what guides me toward refinement, and knowing the sensations created by a ball poorly hit is what helps me avoid mistakes. Kinesthetic sensations are our guides to comparing movement options, choosing whether to

change a pattern or stay with the tried and true, and being able to reproduce that new pattern accurately and reliably. These sensations include an ability to discern joint position, direction and velocity of movement, relationship to gravity, and muscle effort. We cannot possibly be consciously aware of every bit of proprioceptive information coming into headquarters and most of that information is processed subcortically, but the *decisions* based on that information are central to motor learning.

All this proprioceptive information flooding our CNS is to aid in motor decision-making. We make decisions about movement and postural patterns during childhood development, after injury and during subsequent recovery, as a manifestation of an emotional state, or as influenced by cultural aesthetics and more. We make these decisions based on internal and subjective criteria and, once selected as a preferred pattern, quickly turn it into a habit. We *like* that particular way of doing things and habituate our motor *instructions* to create the proprioceptive feeling associated with that preferred pattern. It is this interweaving of motor and sensory, this blending of early learning, emotion, injury history, and culture, that makes kinesthetically driven movement and postural patterns so hard to change and makes our work as clinicians so unpredictable. Clinically, we have to persuade our patients to change from what are often habitually ingrained arthrokinematic, postural, or movement patterns to the new way we propose—showing them a picture, demonstrating proper ergonomics, or handing them a packet of home exercises is often not enough. How then do we as clinicians use exercise to go about changing a valgus knee or protracted shoulder girdle, changing a hypermobile C6, or an impinging glenohumeral joint despite a lifetime of endless and interwoven habit selections?

If our goal in exercise is to change muscle function *in order* to change motor behavior, we need to think about what kind of learning environment we're providing for our patients. Is it reasonably quiet or is there loud music or ongoing conversation? Are they paying kinesthetic attention while they are doing their exercises or are they reading a magazine or worrying about work? Ignoring kinesthetic cues is easy enough in the best of conditions; un-

necessary distractions will make the job even more difficult.

How do we train them for kinesthetic acuity? We could ask them questions about what they notice about themselves while they move or assume a posture; we could verbally guide them on their search for proprioceptive clues. How do we guide them in their decision-making process? We could ask them to feel for smoothness, ease, comfort, effortlessness, and balance which lets them use their own internal and subjective criteria and select new patterns from a number of deliberately introduced choices. What do we want them to be aware of? In addition to joint position and movement, effort sense, etc., we particularly want them to be able to recognize patterns—the *whole-body or integrated patterns* of movement and posture that make up our real life.

PATTERN SPECIFICITY: GLOBAL AND DIFFERENTIATED PATTERNS

Let's imagine the case of the hyperlordotic patient with low back pain. His pain is aggravated by standing, lumbar extension, and lying on his belly and is alleviated by lumbar flexion. A diagnosis might be a closed-pack facet irritation, SI strain, or even a spondylolisthesis, and we may give him exercises to strengthen his hip extensors to reduce excessive anterior pelvic tilt in standing. Gluteal sets, prone leg lifts, or hands and knees diagonal arm and leg lifts may be prescribed and progressive resistance techniques can be applied. These would certainly quantitatively strengthen the hip extensors, but would they necessarily change the behavior contributing to his pain? On skeletal and muscular analysis, we can see that both the hip and spine are in extension and both the hip extensors and the back extensors are engaged in shortening contractions. This pattern of simultaneous hip and back extension we could call a global extension pattern). Our clinical intention, however, is for the patient to do a differentiated pattern of movement, hip extension along with lumbar flexion (Figure 1). We want a contraction of the hip extensors with inhibition of the back extensors. We want the hip extensors to work to posteriorly tilt the pelvis without the lumbar extensors kicking in to keep the low back extended in hyperlordosis.

Try the following simple experiment. Lie on your belly with your legs long and comfortably spread. Keeping both knees on the ground, slowly lift both feet 1"-2" off the floor and lower them back down. Repeat many times to feel and be aware of what happens at your pelvis and lower back as you do this. In theory,

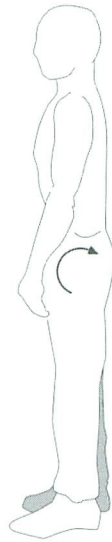


Figure 1

the contraction of the hamstrings *should* posteriorly tilt the pelvis and lengthen or flex the lumbar spine. What many of you will find, however, is that the lumbar extensors automatically kick in to counteract the posterior tilting function of the hamstrings. As you continue this movement some of you may *learn* to allow the lumbar spine to flex through the inhibition of the back extensors. Some others of you will be unable to differentiate the hip and lumbar extensors and allow the pelvis to flex in this position no matter how many times you try. This becomes an even more difficult differentiation to make if we add in the gluteals by lifting the knees. Try it yourself to see if you can do it without activating the back extensors!

Developmentally, lying on our bellies and contracting our hip extensors is *associated* in our CNS not with standing (balance), but with lifting our head to look around (orientation). When at a certain age, children will spend a lot of time on their bellies with their head, arms, and legs all lifted in a global extension pattern. Try lying on your belly and lifting your head to look forward without pushing up with your hands. Feel at what point your gluteals and hamstrings kick in. In this situation the lumbar and hip extensors *should be* working together, as they are synergists in the intention to bring the head to vertical and look around. In our hyperlordotic patient, however, we would like the hip and lumbar extensors to be antagonists in the desired action of posteriorly tilting the pelvis to better *balance* it over the legs, reducing hyperlordosis, and its consequent tissue strain. This requires a differentiated pattern of movement, hip extension with lumbar flexion. In motor learning terms, then, there needs to be

pattern specificity in our exercise prescription. The pattern we strengthen a muscle should look something like the pattern of movement we are trying to teach to our patients. In other words, we can think of strengthening the pattern, not just the muscle.

Let's look at another example. Say we have someone with a habitually slumped sitting posture who complains of headaches and neck pain. We would like to teach this patient to extend his thoracic spine and come upright to better balance his head and relieve muscular strain, joint compression, or shearing in the cervical spine. We would likely prescribe exercises to strengthen the back extensors. We may even, as in our last scenario, have our patient do prone or hands and knees arm and leg lifts. This again quantitatively strengthens the back extensors...but by combining back extension with hip extension (and upper extremity extension) we are again teaching a global extension pattern. Our clinical intention with this person is for him to move in the direction of a differentiated pattern of movement that involves back extension with hip flexion (Figure 2). Here the iliopsoas are synergists to the back extensors while the hip extensors need to be inhibited and allowed to lengthen, as they are now antagonistic *in this function*.

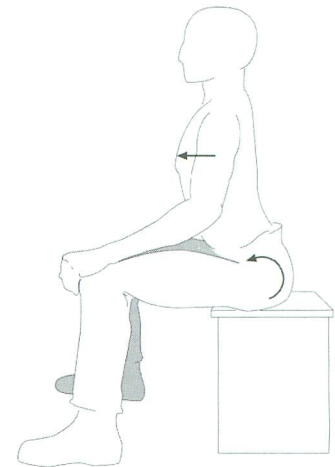


Figure 2

For some people, we may even want to go further to differentiate the lumbar extensors from the thoracic extensors. This would be especially true with our patients that are simultaneously extending their low back and flexing through their mid-back, which is another common variation on our patient with neck pain and headaches. Here, the challenge is to get the thorax to extend simultaneously with lumbar flexion. Try it out in a chair (Figure 3), then in standing! It can be very difficult for many people!

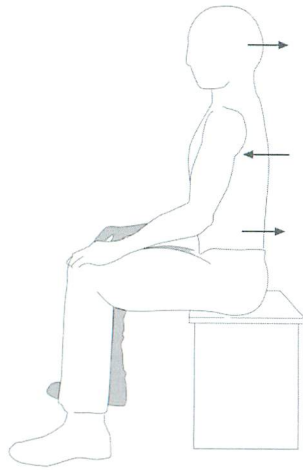


Figure 3

With pattern specificity in exercise comes pattern recognition on the part of the patient. Exercising specific patterns of movement in a variety of positions and orientations to gravity allows our patient to know what he is doing, to recognize the pattern of the movement, and to apply it to real-life function. With pattern specificity comes whole-body, integrated patterns of movement and the coordination of both local and distal synergistic muscles with the muscle we are trying to strengthen. With pattern specificity comes the ability to simultaneously inhibit the antagonists, using reciprocal inhibition and progressive application of constraints to stretch the muscles opposing our desired function. Instead of stretching and strengthening different muscles in isolation, we could use pattern specificity to simultaneously do stretching and strengthening exercises, postural training, kinesthetic acuity training, and spinal stabilization and body mechanics instruction. Let's look at some simple examples to illustrate what pattern specific exercise and qualitative strengthening might look like.

We may have our first student lie on the floor with knees bent and feet flat. We might have him alternately lift and press his tailbone (Figures 4, 5) or to roll his pelvis up and down on the floor by pushing and pulling with his legs. The pressing of his tailbone exaggerates his pattern and allows him to judge its familiarity and comfort. This is the differenti-

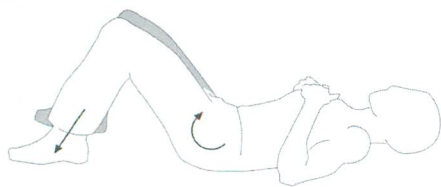


Figure 4

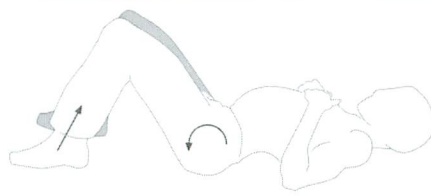


Figure 5

ated pattern that causes him problems in standing, back extension with hip flexion. The lifting of his tailbone is a nonhabitual differentiated pattern of hip extension with lumbar flexion. It is really the classic *pelvic tilt* but done for motor learning purposes with pattern reciprocity and change of venue. Pattern reciprocity is simply "going in both directions" instead of only going in a "therapeutic direction." In the case of our hyperlordotic patient, logic might dictate that we want to move in the direction of comfort only, lumbar flexion/hip extension. For pattern recognition and decision-making considerations, however, reciprocal movements are more informative, even if we can only move a small amount into that direction of strain or hypermobility. Reciprocating movements help our CNS to map where we are in a movement continuum and allow us to more accurately recalibrate "neutral." Reciprocating movements also help to coordinate the antagonists pairs by having them engage in a cooperative "tug-of-war."

Change of venue has to do with taking the same reciprocating patterns and introducing an element of change. We could change speed, orientation to gravity, or intention. We might have him enlarge the movement by lifting the pelvis off the ground and lifting and lowering the lumbar vertebrae *one at a time*. We could have his feet on the wall instead of the floor while doing the same things and have him progressively move his feet closer to the floor (Figures 6, 7). We could stand him up with his butt on the wall, his feet away from the wall, and leaning with his hands on his knees. Then we could have him reciprocate patterns here and progress by standing

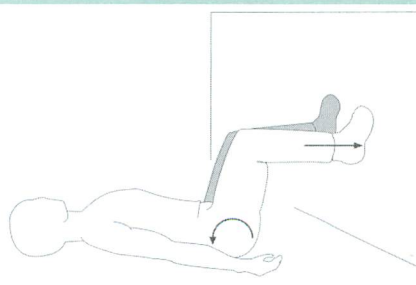


Figure 6

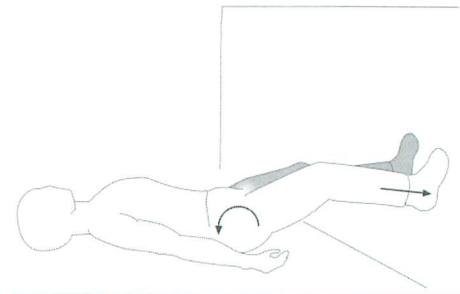


Figure 7

erect and moving the feet ever closer to the wall. We could take the same basic reciprocal patterns and do them supine, side-lying, hands and knees, 4-point, 1/2 kneeling, or sitting on the floor or a chair. We could introduce one-sided versions of this alternating movement and do diagonal patterns in addition to cardinal plane movements. These changes of venue help our patient with recognizing *pattern variations* and allow him to extrapolate skills learned here to similar functions, becoming more creative and self-regulating.

We could have our slouching patient with the neck pain and headaches roll his pelvis deliberately forward and backward and look up and down in coordination. We could progress this to leaning back/rolling back/looking down and leaning forward/rolling forward/looking up (Figure 8, 9). These are again reciprocating differentiated patterns with the movement into hip flexion and back ex-

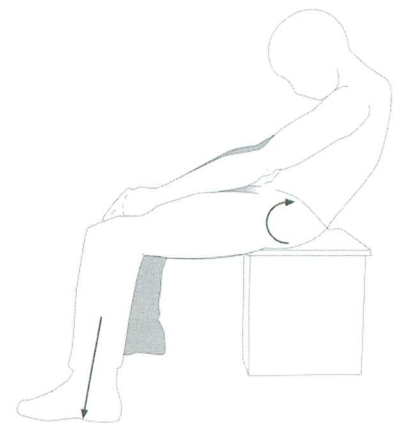


Figure 8

tension being the nonhabitual pattern we want. Movement into this direction simultaneously strengthens the iliopsoas and back extensors while lengthening/stretching the hamstrings, piriformis, gluteals, abdominals, anterior chest wall, etc. We could progress this by rolling the pelvis forward and back while leaning on elbows, or with hands on the floor. We

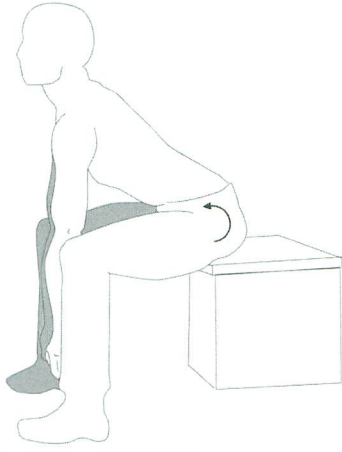


Figure 9

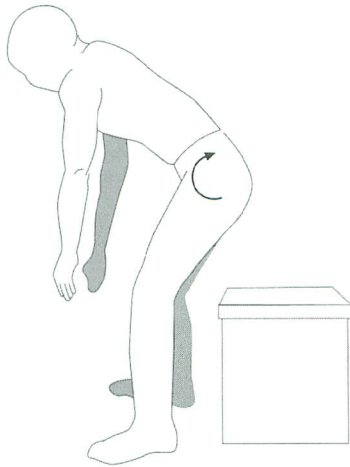


Figure 10

could turn it into a transitional movement from sitting to standing (Figure 10), or an ergonomic movement of bending to lift (Figure 11). Clinically, we are not just asking him to come from slouching to erect sitting but to go beyond vertical to gain competence in a non-habitual direction of movement. It is this ability to move “equally well” in both directions that allows a more appropriate neutral and balanced posture to emerge organically.

In the case of the simultaneously lordotic low back and kyphotic mid-back, we could arrange conditions in which we can globally extend the whole spine then constrain thoracic flexion by use of a towel roll while tilting the pelvis posteriorly and flexing the lumbar spine (Figure 12). Changing orientation, we could constrain lumbar extension through extreme hip flexion and allow wiggle room for mostly thoracic extension. Apply principles of pattern specificity and change of venue and be creative!

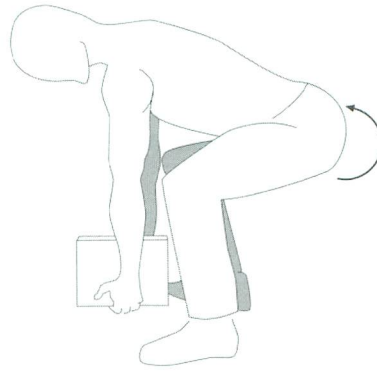


Figure 11

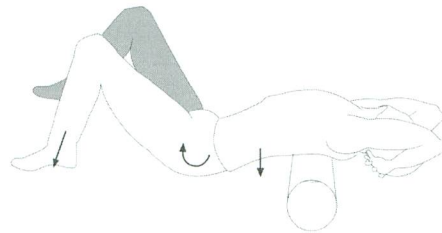


Figure 12

Illustrations by Eric Solomon

FUNCTIONAL CONTEXT

Functional context refers to our ability to piggyback information or skills we would like our patient to have concerning posture, strength, flexibility, and kinesthetic acuity onto real-life movements. Consider for a moment *why* we move, *why* we tell our muscles to move our bones. We mainly use our muscles in order to **balance** ourselves in a gravity field, to **orient** all 5 extero-receptors but especially our eyes to our surroundings, to **locomote**, to make **transitions**, to **manipulate**, to **communicate**, and for **vegetative** functions. We rarely *intend* to extend our hip joints, rotate C6 to the left, or move our scapula. We often, however, have the intention to stand, to look to our left, and to reach forward. We rarely *intend* to move our mandible but we do talk and eat. We rarely *intend* to side-bend our torso but may need to bend in coordination with a balance reaction. We rarely *intend* to move our ribs or contract our intercostals but always have a strong motivation to breathe.

As infants we are born with the ability to breathe, eat, digest, eliminate, and circulate fluids, but little else. We progressively learn to orient, balance, manipulate, etc. in a process we call the developmental sequence. There is going on all through development an intimate meshing, an interweaving of intention, sensation, and action. These connections remain throughout our lives, but if we as therapists can tap into these associations of musculoskeletal organization and real-life intention,

we'll have a powerful tool for helping correct many of the postural, arthrokinematic, and gross motor *mistakes* that bring people to our offices in pain. Linking our exercise to functional context is what makes that exercise both informative and comprehensible to our CNS. Intentionally moving the eyes, hands, mouth, and feet and linking them to whole-body patterns of movement is a common strategy in motor learning. Relearning movement patterns first seen as part of the developmental sequence is another way of accessing forgotten skills and applying those skills to present-time and real-life activities that might have *grown out of* those previous steps. Breaking down a mature function like walking or throwing into its constituent parts and building it back up again piece by piece is another strategy. In summary, functional context is both our information delivery system *and* the glue that *makes it stick*.

CONCLUSIONS

If we as physical therapists acknowledge that much of our work with patients involves motor learning, we need to ask ourselves about the efficacy of our motor teaching technique. *What do we want to teach and how do we want to teach it?* Habituated motor patterns will often be unresponsive to cerebral arguments and an imitation and repetition style of teaching. Using visual information and scientific reasoning to teach kinesthetic skills and organic intelligence may be sporadically effective but lacks subtlety, refinement...elegance.

With some modifications in how we use therapeutic exercise, we can further excel in our roles as movement teachers. Elevating patient self-awareness and enhancing kinesthetic acuity helps them become better problem-solvers, self-regulators, and decision-makers. Pattern specificity helps with antagonist coordination, pattern recognition, and incorporation of the affected part with the integrated whole. Functional context provides relevance, is consistent with how we learn developmentally, and is the *glue* that helps the CNS to functionalize exercise.

Knowledge of anatomy and pathology, while crucial to clinical excellence, is not by itself complete. We need to recognize how bodies move and why. We need to recognize how biomechanical errors happening distally to the manifested pathology contribute to that pathology. We need to recognize the interrelationships of bone, joint, muscle, connective tissue, and *brain*. We need a new exercise paradigm for the new information age.

Gordon Browne, PT is in private practice in Bellevue, Washington and teaches motor learning seminars to PTs and other health care practitioners.

What's New in OCS - Orthopaedic Certified Specialization?

Jean M. Bryan, MPT, PhD, OCS

Orthopaedics leads the way in the number of board certified specialists. There are currently 1,653 Orthopaedic Certified Specialists, which make up 52% of all certified specialists. The specialization process began over 15 years ago and the process continues to evolve and change. From the beginning, the American Board of Physical Therapy Specialties (ABPTS) planned to streamline the application process once the psychometric properties of the examinations were clearly established. The application process is much simpler today than it was even 10 years ago with less documentation required of the applicant.

RECENT CHANGES IN ELIGIBILITY

One of the biggest changes is the ABPTS' decision in 1999 to change the practice eligibility requirements to take the specialist exam. The new requirement, in effect for the 2001 exam, is 2000 hours of direct patient care in the specialty area within the last 10 years. At least 25% of these hours must have occurred within the past 3 years. On the surface, this looks like someone could apply and sit for the exam with just 1 year's experience; however, this is not likely because direct patient care must include activities in each of the elements of patient/client management applicable to the specialty area and included in the *Description of Advanced Clinical Practice* (DACP). These elements, as defined by the *Guide to Physical Therapist Practice*, are examination, evaluation, diagnosis, prognosis, and intervention. Because most therapists participate in other activities in addition to direct patient care (ie, consultation, administration, continuing education), accruing 2000 hours of direct patient care in 1 year may not be possible.

Why did ABPTS Make this Change?

Going from 5 years of practice with 3 years of orthopaedic practice to only 2000 hours of direct patient care in orthopaedics appears to be a radical change. However, ABPTS' decision was based on the consideration of a number of factors, such as (1) no scientific data exist to support the assumption

that increased years of physical therapy practice improves readiness to sit for the examination or expands the depth or breadth of clinical experience, and (2) there are no assessment mechanisms in place for measuring the quality or outcomes of physical therapy practice hours.

Are New Physical Therapists Ready to Pass the Orthopaedic Specialty Exam after Only 2000 Hours of Direct Patient Care Practice?

Instinctively, one might think they were not. But in terms of passing the exam, we do not know the answer to this question since previously candidates had to have 5 years of experience in order to take the exam. However, as mentioned above, there is no standard as to practice hours and no assessment mechanisms in place for measuring quality or outcomes of those practice hours. A candidate could have 2000 hours of varied experiences or 100 hours of experience repeated 20 times. If the 2000 requisite hours are in a very limited area of orthopaedics, the candidate may not have sufficient clinical experience to take and successfully pass the exam. The certification examination assesses a clearly defined domain of knowledge and skills in orthopaedic physical therapy that are beyond entry-level practice. Candidates are certified upon achievement of a passing score on the examination.

Since orthopaedic physical therapy encompasses such a broad area, it is likely that most potential candidates will not feel prepared to take the exam as soon as possible, ie, the 2000 hours. Applicants are strongly encouraged to assess their readiness to sit for the examination. The Self-Assessment Tools for Physical Therapists, available from the APTA's Service Center or the internet, can help potential candidates decide when they have the requisite experience, knowledge, and skill base to be ready for the specialization process. The self-assessment process can also help candidates set up a study program to meet their specific needs in order to prepare for the exam.

Who Benefits from these Changes?

Since more therapists will be eligible to take the examination, we do expect more therapists to take the exam before they reach the previous minimum of 5 years of practice. However, 2 groups in particular really benefit from this change. One is academic faculty who maintain only a part time practice. Under the previous requirements, they often were not able to accumulate enough hours to qualify to take the exam. As such, some of our very best clinical specialists were precluded from the specialization process. The same applies for therapists who are in administration or for other reasons have a limited patient load. They will now have the opportunity to become certified specialists.

What about the Passing Scores? Will they Change?

The specialist certification examinations are criterion referenced, and the passing score for the exam is based on the content of the exam and an analysis of candidate performance. Each specialty council forms a standard-setting committee composed of individuals who represent the spectrum of practitioners in the specialty and who are diverse in the origins of their practice, theoretical approaches, practice settings, geographic area, sex, and race. Each standard-setting committee then participates in a content-based standard-setting meeting conducted by ABPTS's testing agency. An outcome of each committee's standard setting meeting is a recommendation of a passing score for the respective specialty examination. The ABPTS carefully considers the standard-setting committee's recommendation when making the final decisions regarding passing scores for each of the specialty examinations. Even though access to the examination process has been increased, the high standards for successful completion of the examinations will be maintained.

Is This Change Set in Stone?

Not necessarily. During the 2001-2003 exam administrations, the ABPTS and the Orthopaedic Specialty Coun-

AAOMPT 2001 — CALL FOR ABSTRACTS

The 7th Annual Conference of the American Academy of Orthopaedic Manual Physical Therapists will be held October 19-21, 2001 in beautiful San Antonio, TX. Interested individuals are invited to submit abstracts for presentation in slide or poster format. The AAOMPT research committee chairman must receive the abstract and 1 photocopy, by **June 1, 2001**. Abstracts received after this date will be returned. You will be notified of the acceptance/rejection of your abstract in July of 2001. 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 research evaluating 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 around. 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.

RESEARCH PRESENTATION AWARD. The research platform presentation deemed of the highest quality of those presented at the annual conference will be awarded the AAOMPT Excellence in Research Award. This award will consist of an award certificate and reimbursement of the conference registration fee.

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cil will examine applicants' performance on the exam based on a number of applicant characteristics. The ABPTS will change the eligibility requirements for the 2004 exam if warranted. Review of the impact of the change in eligibility requirements will help us identify reasonable minimum practice hours and experiences that are likely to result in passing the OCS exam.

WHAT ELSE IS HAPPENING IN ORTHOPAEDIC SPECIALIZATION?

The orthopaedic specialty examination is based on the Description of Advanced Clinical Practice (DACP) in Orthopaedics. The current DACP is over 8 years old and undergoing review, revision, and revalidation to reflect recent changes in practice. A workgroup of content experts have developed a survey, which will be used to revise and revalidate the DACP. The survey is being pilot tested and will be given to a sample of Orthopaedic Section members, both orthopaedic certified specialists and non-orthopaedic certified specialists. If you would like to participate in this survey, you can con-

tact Jean Bryan (project coordinator) at jbryancoe@mindspring.com or call Andrea Blake at APTA Specialization Department, 1-800-999-APTA, ext. 3150. We value your time and input to make the revised DACP clearly descriptive of what orthopaedic specialists do.

WHO SHOULD YOU CONTACT WITH QUESTIONS ABOUT ORTHOPAEDIC SPECIALIST CERTIFICATION?

Your Orthopaedic Specialty Council (Mike Cibulka, Chair; Robert Johnson; and Nancy Henderson) and the orthopaedic representative on ABPTS (Jean Bryan) work together with ABPTS and its other specialty councils to maintain the integrity of the specialist certification process. Any of these individuals would be happy to talk with you or answer your questions about Orthopaedic Specialist Certification.

In a recent survey of specialists, 75% indicated that specialist certification positively affected their patients. A recent study by Hart and Dobrykowski (Influence of Ortho-

paedic Clinical Specialist Certification on Clinical Outcomes. *J Orthop Sports Phys Ther.* 2000;30(4):183-193) indicates that certified specialists are more efficient compared to clinicians without the OCS. Your orthopaedic representatives are working with ABPTS to uphold the integrity of the specialization process.

Jean M. Bryan, MPT, PhD, OCS was Chair of the Orthopaedic Specialty Council from 1998-2000.

Peer, Utilization and Claim Reviews of Physical Therapists

Carolyn Bloom, PT

Peer review is a system by which peers (same profession and ideally the same area of practice) assess the quality of care provided, using accepted practice standards and guidelines.

Utilization review is a system for reviewing the medical necessity, appropriateness, and reasonableness of services proposed or provided to a patient or group of patients. This can be done on a prospective, concurrent, or retrospective basis to reduce the incidence of unnecessary or inappropriate service.

Claims review is a process of reviewing billing records that may result in identification of issues that may require medical review.

All 3 of these review processes are important for the continued quality and effectiveness of an individual therapist's care and billing practices, which blend together to form the level of perceived physical therapy professional care by consumers, referral agents, insurance representatives, and payers. Unfortunately, many of us are somewhat threatened by having peers review our documentation, evaluations, and patient charts, and certainly shy from paying to have this done. We should have more confidence in our documentation since it is an educational experience and not regulatory requirement, as are JCAHO or other reviews.

The purpose of peer review is to ensure adherence to professional standards and to provide accountability to the community for the quality of physical therapy services provided. It leads to the identification of the need for corrective actions and gives instructive feedback to the therapist. Most state chapters of the APTA have a Peer Review Committee. The Minnesota Chapter has been the most active in this area for the longest period of time, with excellent outcomes. Physical therapists and PTAs are welcome to participate in all chapter-sponsored Peer Review activities. A knowledge is required of the core documents of our profession such as the Standards of Practice for Physical Therapy, the *Guide for Physical Therapist Practice*, The Code of Ethics, The Guide for Professional Conduct, Guidelines for Physical Therapy Documentation, the Guide for Conduct of the Affiliate Member and the multitude of House of Delegate policies on supervi-

sion, delegation, and practice. It is imperative to thoroughly know the PT Practice Act of your state. The Kansas Chapter has developed a 2-page Peer Review Tool that can be used for a facility or self evaluation. This can be obtained by contacting the KPTA's Central Office at 785/233-5400 or skearney@cjnetworks.com.

I have done claims and utilization review for Medicare for 18 years, BCBS for 16 years, and periodically review claims from other private insurance companies. More PTs are asking me about how to get a *foot into the door* in regard to performing claim reviews. Here are my suggestions:

- First, do your homework by attending APTA educational programs on doing claims review, and know the core documents and APTA's Guideline for Physical Therapy Claims Review.
- Update your resume or CV to include your expertise in these areas.
- Ask your state Chapter to provide your name on a list of available reviewers to requesting insurance companies.
- Write a letter of introduction personally to key persons within major insurance and case management companies. Offer to present a program to their nurse/professional reviewer staff on any questions they have regarding physical therapy care, documentation, and billing. This may lead to more questions later, and then a claim being sent to you for individual review.
- Determine what your charge will be either per claim or by the hour, which most companies prefer. It is a bad practice to be reimbursed based on the percentage of billings denied.
- Offer to first review claims that have been denied, but the provider asked for a peer-reviewed *reconsideration* of payment. This would be a *third level* of review, with staff doing the first check of the correct form and boxes, etc. Usually, nurses do the day-to-day claims review with only problem cases or a certain percentage of claims being sent out for peer review, such as by the PT.
- If you contract with an insurance

company, you will receive a Code of Conduct on confidentiality, gifts, falsification of records, personal financial gain, ethics, etc. You must sign a form regarding conflicts of interests.

- Read all the regulations of that insurance company, such as the unit limit per procedural code and other billing guidelines that have been sent to the providers.
- Know the definitions of the CPT codes and what documentation is required to bill that code, and requirements of supervised and constant attendance, as well as number of body parts treated/units billed.

When actually receiving a claim to review, the insurance company staff will send a cover letter asking for your impression of the *appropriateness of care and medical necessity* of care already given (retrospective), or if more treatments should be approved (concurrent), or even if the patient's policy exclusions would rule out coverage (prospective).

For any denial, a complete explanation is required and should be backed by rationale from APTA core documents, or the state's Practice Act. Based on the patient care document provided, the frequency and duration of physical therapy is assessed and compared to the recommendations in *Guide for Physical Therapist Practice*. This is why documentation is so important. Do your current notes give enough information that a reviewer miles away, who has never seen your patient, can get a *mental picture* of your patient's needs, treatment, goals, and progress? If not, you may not get paid, or may be asked for clarification of documentation. Do you have objective goals and data to substantiate your billing? These are needed in order to justify your intervention.

I personally like to have a peer review of my claims by a physical therapist, who actually treats patients him/herself and has enough experience to understand the variability of patient's responses to care. I also bear this in mind when I review other therapist's claims. Denials should be done in an educational manner so this information will be forwarded to the provider through the insurance/management company for improvement and payment

(Continued on page 33)

Practice Affairs Corner

A Revision for the *Guide to Physical Therapist Practice*: Is it Mobilization or Manipulation? Yes! That is my final answer!

Stephen McDavitt, PT, MS

Both the AAOMPT and Orthopaedic Section, APTA, Inc. have realized and recognized that mobilization and manipulation are terms used interchangeably and synonymously. Mobilization and manipulation appear synonymously in various historical descriptions and within schools of manipulative treatment to describe and imply a variety of manual therapy techniques across a spectrum of clinically applied amplitudes and velocities. These clinical terms are used to describe interventions including soft tissue mobilization, craniosacral techniques, myofascial release, joint mobilization, joint manipulation, thrust, oscillations, and articulations. The AAOMPT *Descriptions of Advanced Clinical Practice* (1998) combine and define both terms. ("Manipulation/mobilization: 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.")

Examples of support where manipulation and mobilization are clinical terms used interchangeably and synonymously in various clinical descriptions are supplied for reference below.

1. Gregory Grieve, FCSP, DipTP notes the difficulty in attempting to clarify and categorize various schools of manipulative treatment and describes the use of manipulation and mobilization in manual therapy by physical therapists and others by using these terms interchangeably. In: *Common Vertebral Joint Problems*. Churchill Livingstone; 1988:524. Grieve writes:
 - a.) "Physiotherapists tend to rely on repetitive persuasive and accurately localized [manipulative] techniques which are carefully modulated according to the highly variable nature of the single or combined movement-limiting factor, and particularly according to the joint's and the patient's tolerance. Specific or regional single grade V thrust tech-

niques are occasionally used. Traction techniques, either manually or mechanically applied, are used in their own right yet may be combined with other techniques."

- b.) On manipulation: Defined by the *Oxford English Dictionary* as, "to handle, deal skillfully with, manage craftily," the term manipulation in the professional sense, can be held to cover any manual procedure applied passively to a relaxed body part, often for restoration of joint range and functional relationship. The idea that force and flamboyance must accompany a manipulation is quite wrong. "A specific joint movement of short amplitude and high velocity is occasionally indicated, yet by far the majority of effective manipulative work requires only the use of simpler much more gentle and less dramatic mobilizing procedures."
 - c.) Manipulation: An accurately localized, single, quick, and decisive movement of small amplitude, following careful positioning of the patient. It is not necessarily energetic, and is completed before the patient can stop it. The manipulation may have a regional or a more localized effect, depending upon the technique or position of the patient. (Grieve GP, *Common Vertebral Joint Problems*, Churchill Livingstone, 1981:378.)
2. Quick Reference Guide for Clinicians, Number 14, Acute low Back Problems in Adults: Assessment and Treatment, U.S. Dept. of Health and Human Services, AHCPR: "Manipulation, defined as manual loading of the spine using short or long leverage methods."
 3. Phillip E. Greenman, DO, observed that "There is a wide and varying range of techniques that now fall un-

der manipulation, or spinal manipulotherapy, and if one picks up various textbooks on the subject, one notes whole different systems. They vary from mild mobilization or from very slight movements to various forms of massage, to gross non-specific movements using femurs and shoulders and so on, to minute specific kinds of adjusting techniques which put a specific contact on either a transverse or spinous process and give a very short, sharp thrust. So there is a great variation in techniques by people who claim to be spinal manipulators, and a generalization can never be made from a single qualified practitioner to the entire field of manipulation. Nevertheless, all of manipulation is often dismissed on the basis of one technique" (Greenman PE. Manipulative therapy in relation to total health care. In: Korr. *The Neurological Mechanisms in Manipulative Therapy*. London: Plenum Press; 1978:83.)

4. Manipulation/Mobilization: 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. (DACP AAOMPT 1998. Adopted Orthopaedic Section, APTA, Inc. 2000.)
5. Manipulation: is usually synonymous with the use of thrust techniques but, according to some authors, as exemplified by Lewit (Lewit K. In: *Manipulative Therapy in Rehabilitation of the Motor System*. London: Butterworths; 1985.), the term covers all techniques applied in manual therapy, which is a broader term. (Blomberg S. *A pragmatic approach to low-back pain including manual therapy and steroid injections. A multi center study in primary health care*. Department of

Family Medicine, Uppsala University, Uppsala. ISBN 91-554-3030-9)

6. Manipulation infers that manipulation is a manual procedure to treat joint dysfunction, which by definition, is a loss of one or more movements of an involuntary nature which can occur at any synovial joint. (Mennell JM. *Back Pain*. Little, Brown, and Company; 1960:29.)

7. Manipulation: Simply defined as a passive movement at a joint with a therapeutic purpose, using the hands. (Cyriax J. *Textbook of Orthopaedic Medicine*. Vol. I, 6th ed. Bailliere Tindal; 1975:701.)

8. Manipulation: This term is used in 2 distinct ways:

1. It can be used loosely to refer to any kind of *passive movement* used in examination of treatment.

2. In a restricted definition, it is used to mean a small amplitude, rapid movement (not necessarily performed at the limit of a range of movement); which the patient cannot prevent from taking place.

Mobilization: This is another *passive movement* but its rhythm and grade are such that the patient can prevent its being performed. (Maitland GD. *Vertebral Manipulation*, 5th ed., Butterworth; 1986.)

9. Other definitions for manipulation/mobilization:

Mobilization: Making moveable; restoring the power of motion in a joint. (*Stedman's Concise Medical Dictionary*, 2nd ed.)

Mobilization: The process of making a fixed part or stored substance mobile, as by separating a part from surrounding structures to make it accessible for an operative procedure or by causing release into the circulation for body use of a substance stored in the body. (*Dorland's Illustrated Medical Dictionary*, 28th ed.)

Manipulation: Skillful or dexterous treatment, as by the hand; in physical therapy, the forceful passive movement of a joint beyond its active limit of motion. (*Dorland's Illustrated Medical Dictionary*, 28th ed.)

Mobilization: To release (something stored in the organism) for bodily use. (*Merriam Webster's Collegiate Dictionary*, 10th ed.)

Manipulation: To treat or operate with the hands or by mechanical means, esp. in a skillful manner. (*Merriam Webster's Collegiate Dictionary*, 10th ed.)

Manipulation: To operate or control by the skilled use of the hands. (*American Heritage Dictionary*)

Manipulation: The skilled passive movement to a joint. (Paris SV, JAPTA, 1979;49(8).)

Manipulation vs. Mobilization: The term "mobilization" is identical in meaning with the word "manipulation." They are interchangeable. Mobilization has been the more common term in the United States due to physical therapists wishing to avoid the word "manipulation" which has to some an implied association with chiropractic. While that might have been true it is no longer the case. In medical journals they refer to manipulation and recognize our role in it. (*Spinal Manipulative Therapy*, Clinical Orthopaedics and Related Research, Paris SV, 1983:179.)

It is evident then that typically mobilization and manipulation are operationally defined within the particular manipulation school or paradigm being practiced, resulting in a synonymous use of terms across the respective descriptions and interpretations of practice.

Both the AAOMPT and the Orthopaedic Section, APTA, Inc. recognize, as Paris and others have, that due to the interchangeable and synonymous use of the term's mobilization and manipulation there is difficulty in attempting to clarify and categorize various schools and definitions of manipulative treatment. These 2 organizations have recognized and appreciated a need to better operationally define manipulation and mobilization in physical therapy. The Orthopaedic Section and the AAOMPT wish not to define manipulation and mobilization according to a particular school or paradigm but as these skilled direct interventions are applied and described in common physical therapy practice and in various practice patterns and conditions within the *Guide to Physical Therapist Practice*. (ie, Manipu-

lation/Mobilization-Pattern 4D1-9).

The present *Guide* (July 1999) separates the definitions for manipulation and mobilization by the descriptive elements of speeds and amplitudes. (See below)

Guide to Physical Therapist Practice
American Physical Therapy Association

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.

Appendix 1-3 Guide to Physical Therapist Practice American Physical Therapy Association © 1999, 1997 by the American Physical Therapy Association (APTA). Revised July 1999. American Physical Therapy Association. For more information about other APTA publications, contact APTA, 1111 North Fairfax Street, Alexandria, VA 22314-1488, or access APTA's Resource Catalog online via APTA's Web site, www.apta.org/res_cat. [Publication order no. P-139] ISBN 1-887759-16-6

When considering the evidence provided here both the Orthopaedic Section and the AAOMPT proposed to the APTA in July 2000 that it was time to revise the definitions and glossary addressing mobilization and manipulation in the *Guide to Physical Therapist Practice*. Therefore, based on what is presented here, the AAOMPT and the Orthopaedic Section, APTA, Inc. supported and proposed a synonymous definition for mobilization and manipulation for the upcoming revision of the *Guide to Physical Therapist Practice*. "Manipulation/Mobilization: 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." (DACP AAOMPT 1998)

In July 2000 the Orthopaedic Section, APTA, Inc., the AAOMPT, and the APTA agreed on the following definition for mobilization and manipulation for the upcoming new revision of the *Guide to Physical Therapist Practice*.

Mobilization/Manipulation: a manual therapy technique comprised of a continuum of skilled passive movements to joints and /or related soft tissues that are applied at varying speeds and amplitudes, including a small amplitude/high velocity therapeutic movement.

All 3 parties agreed that this definition more appropriately reflected the common skilled practice of mobilization and manipulation in physical therapy and would support the needs for use in describing and defining physical therapy practice, reimbursement, education, research, legislation, and regulation.

Is it mobilization or manipulation? Yes! That is the final answer, and it is about time!

Stephen McDavitt, PT, MS is Co-Chair of the Practice Committee for the Orthopaedic Section APTA Inc. and Chair of Practice Affairs for AAOMPT.

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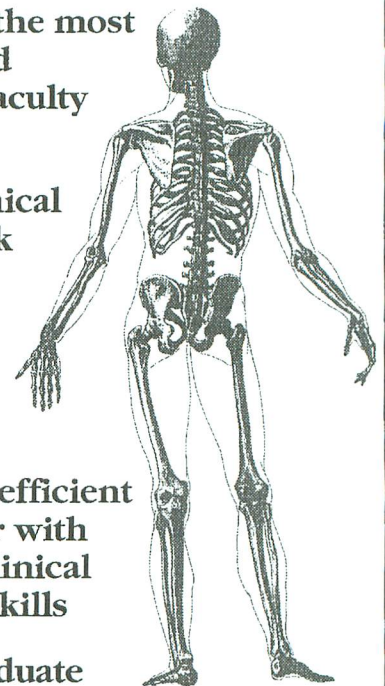
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Essential Treatment of Selected Forearm Fractures

Gary Shankman, MS, OPA-C, ATC, PTA, CSCS

This column is geared toward the physical therapist assistant and is being coordinated by Gary Shankman, MS, OPAC, ATC, PTA, CSCS.

Four distinct types or classifications of elbow and forearm fractures are Monteggia fractures, radial head and neck fractures, Galeazzi fractures, and associated Essex-Lopresti injury.

A Monteggia fracture is a fracture of the proximal one-third of the ulna with associated radial head dislocation. Four classifications of Monteggia fractures have been identified.

- Type I is a proximal ulna fracture with an anterior radial head dislocation.
- Type II is a proximal ulna fracture with a posterior radial head dislocation.
- Type III describes a proximal ulna fracture with the radial head dislocated laterally.
- Type IV is described as the same as a type I with an associated proximal one-third fracture of the radius.

Closed reduction is standard for most cases of pediatric Monteggia fractures. In an adult population an open reduction of the radial head with internal fixation of the ulna with a plate and screws is mandatory. Complications include malunion, nonunion, loss of motion, as well as soft tissue and nerve interposition. The posterior interosseous nerve is commonly involved with latent nerve palsy.

A fall on an outstretched arm can result in fracture-dislocation of the radial head and the proximal ulna and radius. Radial head fractures represent approximately one-third of all elbow fractures and nearly 20% of all elbow trauma.¹ Radial head fractures are generally classified into four types:

- Type I: nondisplaced radial head fracture.
- Type II: Marginal fracture with displacement of the fragment.
- Type III: Comminuted radial head fracture.
- Type IV: Radial head fracture with dislocation.

Treatment options parallel the significance of the injury and will dictate the course of rehabilitation. Usually

nondisplaced type I radial head fractures require a period of immobilization ranging from 1 to 4 weeks. Early active motion is encouraged as pain subsides.

It is important to note that passive motion and stretching is strictly contraindicated during maximum and moderate protection phases of recovery following injury regarding all classification types of proximal fracture dislocation of the elbow. Heterotopic ossification is a common complication with the use of passive mobilization during the early and moderate phases of recovery following elbow fracture dislocation.

Stable type I nondisplaced fractures of the radial head usually heal with good to satisfactory results. Typically, regaining terminal elbow extension may prove demanding even with Type I fractures. Type II displaced radial head fractures can either be treated with an ORIF or excision of the fracture fragment. Comminuted Type III fractures are best treated with excision of the radial head and replacement with a silastic radial head prosthetic spacer.

A modification of this classification system includes useful clinical information and treatment options.² Type I-A fractures present with no mechanical block and are treated conservatively. Type I-B fractures are minimally displaced with either a mechanical block or click present. Treatment includes arthroscopy or open exploration with excision of the osteochondral fragment. Type II-A, although displaced, present with no mechanical block or click. Treatment therefore is conservative. Type II-B fractures present with a mechanical block or click. Treatment is with open reduction and internal fixation, excision of the radial head fracture fragment or excision of the radial head with prosthetic replacement. Type III fractures will present with a mechanical block. These are comminuted fractures requiring radial head excision or ORIF. Type IV-A fractures postreduction with no mechanical block, click, or instability can be treated conservatively with a posterior splint and sling. Type IV-B fractures post reduction which present with a mechanical block will necessitate either an ORIF or excision and prosthetic silastic spacer replacement.

In some cases of radial head fracture

dislocation, the radius may migrate proximally resulting in a shortened radius, disruption of the distal radioulnar interosseous membrane, and subluxation of the distal radioulnar joint (DRUJ). Therefore if pain and discomfort is expressed by the patient at the distal radioulnar joint following excision of the radial head, an Essex-Lopresti injury is considered.

Radiographic confirmation of an Essex-Lopresti injury is made by comparing radiographs of the involved DRUJ with the radiograph of the uninvolved DRUJ. Treatment options include ORIF of the radial head or prosthetic radial head replacement. Percutaneous pinning or splinting of the forearm may be required to reduce and stabilize the distal radioulnar joint. Approximately 2 months following prosthetic radial head replacement, the implant may be removed once the distal radioulnar interosseous membrane has healed. The combination of distal radius fracture with associated disruption of the DRUJ is classically defined as a Galeazzi fracture. Also termed reverse Monteggia fracture, Piedmont fracture or Darrach-Hughston-Milch fracture; the fracture pattern is rare with an incidence of 3% to 6% of all forearm fractures.³ Typically poor outcomes are expected with nonoperative treatment due to the inherently unstable nature of this fracture pattern. It is termed a "fracture of necessity"³ due to the requirement of open reduction and internal fixation of the radius fracture and stabilization of the DRUJ for adequate and satisfactory functional recovery.

The common denominator of rehabilitation remains a criteria based program in which each phase of radiographic confirmation of bone healing is considered concurrently with soft tissue healing constraints. Generally, a 3-phase progression is utilized allowing for maximum protection, moderate protection and a minimum return to function phases of recovery. Recall a hallmark of recovery for most elbow and forearm fractures is regaining terminal elbow extension as well as functional pronation and supination. The demanding nature of full recovery following these specific fracture patterns will challenge the physical therapist and physical therapist assistant to communicate with the surgeon to

develop a program of pain and swelling reduction, and a progressive motion and strength regime. All the while one must be cognizant of all potential complications (nonunion, malunion, nerve palsy, hardware migration) and avoid specific contraindications of passive stretching (to prevent heterotopic ossification) during the early phases of recovery.

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S-EMG Workshops

Glenn Kasman, M.S., P.T.

Surface EMG Evaluation & Feedback Training in Physical Therapy: Musculoskeletal Dysfunction

This course will familiarize the participant with sEMG foundations as well as specific assessment procedures and interventions. Applications cover a broad scope of situations including athletic injury, repetitive strain and worker injury due to motor vehicle accident, chronic pain management, and other musculoskeletal problems.

Workshop Locations & Dates

May 20-21, 2000
 Anaheim, CA

October 21-22, 2000
 Toronto, Canada

December 9-10, 2000
 Southfield, MI

Gabriel E. Sella, M.D., P.T.A., Sc., M.P.H.

Practical Skills and Clinical Decision Making Using Surface Electromyography (sEMG)

This workshop outlines various means & methods to document soft-tissue injuries with a focus on the sEMG modality. This will include surface EMG testing of the head, neck, and trunk as well as the limbs. Biofeedback applications in neuromuscular re-education, sEMG applications, post injury and pain will also be discussed.

Workshop Locations & Dates

June 9-10, 2000
 Toronto, Canada

July 28-29, 2000
 Braintree, MA

October 13-14, 2000
 Philadelphia, PA

Ronald A. Fuller, P.T.A., A.T.R.I.C.

Aquatic Rehabilitation and Surface Electromyography (sEMG) Biofeedback

This workshop will focus on the techniques, use, and potential application of aquatic biofeedback in the clinical rehabilitation and sports training setting. The potential for the application of aquatic biofeedback sEMG will be discussed and participants will be taught how to use a waterproof wrap to cover the electrodes of a conventional, hand-held sEMG unit.

Workshop Locations & Dates

May 6, 2000
 Birmingham, AL

June 10, 2000
 Lowell, MA

July 13, 2000
 Warm Springs, GA



Biofeedback Foundation of Europe

PO Box 21, 3440 AA Woerden, The Netherlands • Tel: 1-800-361-3651 • Fax: 514-489-8255 • E-mail: mail@bfe.org

Book Reviews

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

Lewandoski J. *Assessment of Nonorthopedic Sports Injuries: A Side-line Reference Manual*. Thorofare, NJ: SLACK Inc.; 2000:161 pp, softcover.

According to Mr. Lewandoski, "This book is designed to be used by sports medicine clinicians and students. It is meant to be a quick and user-friendly reference guide to help...evaluate and treat nonorthopedic injuries."

Each of the book's 11 chapters is structured identically. The chapter begins with a brief explanation of the subject, followed by an algorithm for evaluating and differentiating between catastrophic and less serious injuries. Next, tables that detail the algorithm and then describe the general mechanism as well as signs and symptoms of specific injuries are presented. Each chapter concludes with a list of references and bibliography. The book discusses the subjects of syncope, head injuries, cervical spine, facial, eye, dental, thoracic, abdominal, and heat and cold injuries, as well as general medical problems such as shock, nontraumatic abdominal disorders, and exercise-induced allergies.

Overall, the book provides excellent in-depth information about the assessment of these disorders, but there are some limitations of the text. Mr. Lewandoski concedes one of them himself. He writes, "...the algorithms are fairly comprehensive. Therefore, it is strongly recommended that the user review the book before using it on the sidelines." I agree strongly with his suggestion. The algorithms are lengthy and yet the print is small to keep the book's size small. Consequently, they are very difficult to read, especially quickly. I believe they would be more user-friendly if they were printed larger on a fold-out page, thus, keeping the book portable but readable. In addition, points in the algorithm that involve evaluation by the therapist are "shaded in gray for quicker reference." This was a great idea that did not prove to be beneficial to the reader; it did not provide a quick reference simply because the shading did not print very differently from unshaded areas. In fact, instead of causing them to stand out in the algorithm, the shading sometimes made sections more difficult to read. Most of the algorithms also involve visiting either different tables in the book or even different algorithms in the book. Tabs in the book are meant to allow the clinician to "quickly locate a specific algorithm." Each tab is a different shade of gray and this reader did

not find them any more beneficial for finding topics in different chapters than the chapter titles on each page. It would have been more useful and effective to print them in color, or to have them protrude out of the page with a title on each tab.

The tables are well done although at times small while leaving 1/3 or more of the page blank. I especially liked the sample history tables which give examples of probing questions the therapist should ask, as well as the table describing cranial nerve evaluation, and the eye and dental injury tables. All special tests are well described in tables. Where anatomical reviews were done, they were very helpful to the reader. In fact, more anatomy figures such as a brachial plexus diagram in the cervical spine injury would have been welcomed. In chapter 10, heat and cold injuries are discussed without clear explanation of the differences between heat exhaustion and stroke, until after tables outlining their treatment. A discussion of the different signs and symptoms in the introduction instead of classifying them simply as "Heat Injuries" would have been beneficial, particularly because a clinician would not want to even begin treating a case of heat stroke, thinking it may be heat exhaustion.

The book offers very good information regarding nonorthopedic sports injuries and exceeded this reader's expectation of comprehensiveness. It fits a huge amount of information into a book that truly is portable. However, there are some simple things that would have made the book more *user-friendly* as the author intended it to be. It is a book that if purchased does need to be reviewed extensively so that items can be found quickly, before using it on the sidelines in a potential medical emergency.

Allyson L. Baughman, MPT



Rucker KS. *Chronic Pain Evaluation: A Valid, Standardized Assessment Instrument*. Boston, Mass: Butterworth Heinemann; 2000:156 pp., illus.

This book provides information on the development of the Pain Assessment Instrument (PAI), designed for use as a multidimensional, multiperspective, comprehensive tool to evaluate chronic pain. The PAI is the product of a research contract, titled the Pain Assessment Instruments

Development (PAID), commissioned by the Social Security Administration in 1990 to develop an instrument for subjective measurement of pain, categorization of pain claimants, and prediction of return-to-work potential. The purpose of the Pain Assessment Instrument is to provide a valid, reliable, multidimensional, and standardized assessment tool to assist in the evaluation of chronic pain in determination of disability.

The book is divided into 7 chapters that focus on the development and evaluation of the PAI and 4 appendices that comprise the 4 sections of the PAI instrument. Chapter 1 briefly describes the development of the PAI, including the conception of the project, the purpose and development of the instrument, and implications of the PAI on data collection and decision-making for the assessment of chronic pain. Chapter 2 discusses the various uses of the Pain Assessment Instrument by first defining chronic pain, then addressing the need for and use of the PAI, and concluding with recommendations for future use of the instrument. Chapter 3 provides a detailed description of scientific validation of the Pain Assessment Instrument. The PAI was assessed for concurrent, construct, and content validity as well as rater reliability (test-retest and interrater) and index reliability, which are discussed in moderate detail. Chapter 4 provides a brief description of the content of the PAI, which includes the Pain Screening Instrument, the Patient Assessment Instrument, the Physician Assessment Instrument, and the Integrated Pain Report. Chapter 5 addresses the administration and utilization of the PAI and contains helpful hints to ensure that test administrators complete the assessment, assign appropriate ratings to patients, and phrase questions to help respondents understand the meaning of the questions. Chapters 6 and 7 are reprints of articles written by the author of the book and published in *Clin J Pain* that further discuss the validation of the PAI. The actual PAI is provided in the 4 appendices: Appendix 1, Pain Screening Instrument; Appendix 2, Patient Assessment; Appendix 3, Physician Assessment; and Appendix 4, Integrated Pain Report. The instrument is lengthy, comprising 30 pages of the book and reportedly requires an average of 55 minutes to complete (SD = 21 minutes).

A stated purpose of the book is to make the PAI available to scientists, clinicians, and private disability insurance com-

panies; however, the PAI appears intended for use by physicians who perform disability assessments. Physical therapists may find the Pain Screening Instrument section of the PAI an interesting, short tool to document a patient's history of pain. It contains 10 items addressing subjective reports of frequency, duration, intensity, and quality of pain experienced by the patient over the past week and past 6 months. However, the author is careful to emphasize that the Pain Screening Instrument was created as a result of the research project and has not been independently validated.

This book is a compendium on the development, evaluation, and use of an instrument for assessment of chronic pain. Although the PAI as a whole may be a carefully designed, valid, and reliable instrument to assess chronic pain, its practical usefulness to physical therapists appears limited. Clinicians and educators who seek information on tools recommended for use in the medical profession to assist in disability determination may be interested in learning about the instrument. However, because the PAI is a newly released assessment tool, its selection as an instrument of choice for assessment of chronic pain and determination of disability is yet to be determined.

Brenda Boucher, PT, PhD, CHT

Jordan C, Mirzabeigi E: *Atlas of Orthopaedic Surgical Exposures*. New York, NY: Thieme; 2000:217 pp., illus.

Atlas of Orthopaedic Surgical Exposures is a collection of photographs and text intended to increase orthopedic surgeons' knowledge of surgical anatomy and to prepare them for various surgical approaches. (Surgical approaches are the means by which internal structures are accessed.) This book was written by 2 physicians and was developed out of their frustration with the failure of texts to provide realistic images of surgical anatomy. While most texts on this subject use drawings or pictures of predissected specimens, this text contains photographs of fresh cadaver specimens and thereby provides the reader with a more accurate depiction of what will actually be seen in surgery.

This book is divided into 13 sections: shoulder, upper arm, elbow, lower arm, wrist, hand, hip, thigh, knee, lower leg, ankle, foot, and spine. Within each section is a collection of cases that are descriptions of commonly used surgical approaches. Some cases presented in the shoulder section include the deltopectoral, posterior, deltoid splitting, and transacromial approaches. For each case, the following topics are discussed: uses,

advantages, disadvantages, structures at risk, technique, and "how to tell if you are lost." Also included in each case is a series of photographs that visually depict each step of the surgical approach, beginning with the initial incision and ending with the final layer of dissection.

The main advantage of this book is its ability to describe various surgical approaches through its use of detailed words and pictures. While this book is obviously intended for orthopedic surgeons, it would also serve as a helpful reference for physical therapists that treat postsurgical patients. One limitation for physical therapists is that this book describes surgical approaches, not procedures. Perhaps of greater interest to therapists would be a text that uses as much graphic detail to describe actual surgical procedures. While *Atlas of Orthopaedic Surgical Exposures* most likely succeeds in meeting its objective of being a teaching tool for surgeons, it is of lesser value for physical therapists. Notwithstanding, it will enhance therapists' knowledge of surgical anatomy and improve their understanding of surgical approaches.

Phyllis A. Clapis, PT, MS, OCS, CSCS

Schunk C, Reed K. *Clinical Practice Guidelines: Examination and Intervention for Rehabilitation*. Gaithersburg, Md: Aspen Publishers Inc.; 2000:493 pp.

Carol Schunk and Kelly Reed have significantly enhanced their contribution to the practice of Physical Therapy with this update of the *Clinical Practice Guidelines*, first published in 1995 as a 3-volume set.

This edition is true to the authors' intent: "to point a direction, not to lead"... clinical interventions. The design of the book provides summary overviews of 89 diagnostic categories seen by physical therapists. Organization covers ICD-9 codes and is cross-referenced with the APTA's preferred practice patterns from its *Guide to Physical Therapist Practice*.

Specific guidelines include functional goal statements and patient instruction, with detailed and progressive intervention strategies that support outcome expectations. While the first books emphasized orthopedic conditions almost exclusively, guidelines for general medical complaints and neurological problems are a significant and important addition to this volume. A separate section on returning to sports is also included.

I would suggest that *Clinical Practice Guidelines* is a *must* for both clinical and personal libraries. Information is included for new and veteran therapists alike. The authors suggest the book be used to pro-

vide in-service education study topics, and as an adjunct to clinical problem solving. It also gives clear guidance to clinicians working toward *best practice* strategies in their facilities as we examine patient outcomes, efficacy, and efficiency in practice.

Jill Floberg, PT

Irion G. *Physiology: The Basis of Clinical Practice*. Thorofare, NJ: Slack, Inc.; 2000:410 pp, hard cover, with accompanying instructor's manual.

Glen Irion, PT, PhD, CWS has provided a physiology text for clinicians and students. This text is unique with its numerous clinical scenarios relating to the chapters being discussed. *Physiology: The Basis of Clinical Practice* has 29 chapters and is broken down into 6 major units. These units are Homeostasis, Neuromuscular System, Integumentary System, Musculoskeletal System, Cardiopulmonary System, Smooth Muscle, Gastrointestinal, and Reproductive System. Study questions follow each chapter. Dr. Irion's attempt to emphasize the clinical practice in physical therapy to physiology may appear to reduce some topics and overemphasize others. Examples are the lack of a chapter on the endocrine system. Dr. Irion states "the regulation of body fluid composition and the role of parts of the endocrine system are emphasized greatly." The scope of the digestive system has also been reduced greatly compared to classic textbooks as well as the section on blood. Units on skeletal muscle and the nervous system are in comparison much larger than typical physiology texts. I enjoyed the unit on the neuromuscular system. The organization of the nervous system, membrane potentials, synaptic transmission, sensation, pain, sleep, and states of consciousness were very well explained. Furthermore, the relationship of the neuromuscular system to physical therapy modalities was very insightful and valuable.

I would recommend this text to instructors who teach entry-level physiology to physical therapy students. I would also highly recommend this text to clinicians that are returning to academics, especially returning DPT students. Practicing clinicians also would benefit from having this text. Reference to the physiology and electrical stimulation section would assist when the *latest and greatest* device comes to market along with assisting a PT diagnosis from impairments to function. This text is a good step toward building a bridge between the art and science of physical therapy.

Daryl Lawson, MPT

Orthopaedic Section, APTA, Inc.

Fall Board of Directors Meeting

MINUTES

The 2000 Fall Board of Directors Meeting was called to order at the Section office in La Crosse, WI at 10:00 AM on Saturday, October 7, 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
Susan Appling, OP Editor
Phil McClure, Research Chair
Michael Cibulka, Specialization Chair
Stuart Platt, Finance Committee Member
Steve McDavitt, Practice Co-Chair
Carolyn Wadsworth, HSC Editor
Terry Randall, Public Relations Chair
Mary Ann Wilmarth, Nominating Chair

Terri DeFlorian, Executive Director
Tara Fredrickson, Executive Assistant

Absent:

Lola Rosenbaum, Education Chair
Paul Howard, Education Vice Chair
Randy Roesch, APTA Liaison
Tom McPoil, FASIG President
Jennifer Gamboa, PASIG President

MEETING SUMMARY:

The agenda for the 2000 Fall Board of Directors Meeting was approved as printed.

The minutes from the 2000 Annual Conference Board of Directors Meeting in Indianapolis, IN were approved as printed.

ACTION ITEMS:

=MOTION 1= The Orthopaedic Section investigate the development of a position statement supporting clinical residency education for entry and post entry-level physical therapy.=PASSED=

Support Statement: It is assumed that the Orthopaedic Section will work with the Education Section and the APTA Educational Division in the development of this position statement.

Fiscal Implication: None

=MOTION 2= Select a liaison to develop formal communications with The American Society of Orthopaedic Physicians Assistants (ASOPA).=PASSED=

Support Statement: The Orthopaedic Section has a policy statement regarding internal and external liaisons. We have common legislative and clinical concerns with other organizations such as the Nurse Practitioners (AANP & ACNP), and Physician Assistants (AAPA & ASOPA). These organizations can utilize our experience in the legislative arena. Our benefit comes from working closely with potential referral sources.

Fiscal Implication: Some cost may be incurred if travel to their meetings is desired.

=MOTION 3=The Criteria for selection of the Student Guest should include: Orthopaedic Section member, in last year of training demonstrated activity/interest in Orthopaedic Physical Therapy (as described by the candidate in 250 words or less), recommendation from one faculty member and one PT at large. Post meeting presentation by recipients to their class on the benefits of membership, complete with application forms!=PASSED=

Fiscal Implication: None

=MOTION 4=Move that the Section solicit proposals to investigate the use of teleconferencing for potential continuing education, business meetings, teleconferencing, and patient conferences. At least three proposals will be solicited.=PASSED=

Fiscal Implication: None

=MOTION 5=Move that the Section solicit proposals for a web-based continuing education course. Proposals should be received in time to be revisited at CSM 2001.=PASSED=

Fiscal Implication: None

=MOTION 6=To limit practice analysis funding to SIGs only.=PASSED=

Fiscal Implication: None

=MOTION 7=Pay CSM conference registration for the Board of Directors (President, Vice President, Treasurer, 2 Directors, Education Chair, Research Chair, Practice Chair) and Nominating Committee Chair beginning with CSM 2001.=PASSED=

Fiscal Implication: \$295 x 9 = \$2,655

=MOTION 8=The Orthopaedic Section will contribute \$200,000 in 2002,

\$125,000 in 2003, and \$125,000 in 2004 contingent upon reaching an agreement with the Foundation for Physical Therapy regarding the nature of the research and the Orthopaedic Section reserves remaining at 70% of operating expenses or higher.=PASSED=

Fiscal Implication: \$450,000 over 3 years (2002-04)

=MOTION 9=Move to finance a modified market appraisal to determine relative real estate values for future real estate investments in building expansion and rental revenues. =PASSED=

Fiscal Implication: \$1,000

=MOTION 10=It is the position of the Orthopaedic Section, APTA, Inc. that Orthopaedic Section continuing education opportunities be available to participants outside the profession of physical therapy and that related credentialing for all participants be consistent in the areas of content, goals, and objectives in accordance with the *Guide to Physical Therapist Practice* and the Normative Models of Physical Therapist and Physical Therapist Assistant Education. Non-physical therapists may participate in cognitive components (learning) but not participate in the psychomotor (laboratory experiences) components unless validated within the practice scope of their profession.=PASSED=

This motion passed contingent upon review so as not to conflict with any House of Delegate policy.

=MOTION 11=Replace motion 6 in the Annual Conference Board of Directors meeting minutes (June 10, 2000) with the mobilization/manipulation statement in discussion item 19 from the Fall Board of Directors meeting 2000.=PASSED=

It is the position of the Orthopaedic Section, APTA, Inc. that mobilization and manipulation be defined as:

Mobilization/manipulation: a manual therapy technique comprised of a continuum of skilled passive movements to joints and /or related soft tissues that are applied at varying speeds and amplitudes, including a small amplitude/high velocity therapeutic movement.

Fiscal Implication: None

=MOTION 12=The Orthopaedic Section fund up to \$30,000 for the proposed "Consensus Conference on Physical

Therapy Specialist Practice and the Specialist Certification Process," contingent on raising funds by other sources for the total cost of the conference (\$58,000).=PASSED=

Fiscal Implication: \$30,000

=MOTION 13=The Section will fund one representative from each SIG to the Fall Board Meeting each year beginning in 2001.=PASSED=

Fiscal Implication: The expense will come out of the Governance budget. This is a requirement to attend not an option.

POLICIES:

POLICY ON FISCAL RELATIONSHIP BETWEEN SIGs AND THE ORTHOPAEDIC SECTION, APTA, INC.

I. PROCEDURE FOR FORMING A SIG WITHIN THE ORTHOPAEDIC SECTION

- A. CSM: Each prospective SIG will conduct educational programming during CSM (Orthopaedic Section will fund under the Education Program).
- B. **Submit to the Section office by July 1:** Petition must be presented to Orthopaedic Section containing at least 200 signatures of active and/or affiliate members of the Section interested in joining the SIG along with the mission and goals of the proposed group.
- C. **May 1:** All draft budgets must be submitted to the Section office. The Finance Committee will review at their meeting in August. Each budget should include travel and one day lodging/meals for the person who plans and moderates the SIG's CSM programming. Requests for funding in excess of \$5,000 will be reviewed by the Finance Committee. It is up to the Finance Committee whether or not to recommend these requests to the Board of Directors at their Fall Meeting.
- D. **Board of Director Fall Meeting:** Consider SIG petition and recommended budget from Finance Committee. Review and approve bylaws or standing rules and other documentation.
- E. **Submit to the Section office by December 1:** The bylaw template developed for SIGs should be completed and submitted to the Section office. The Board will review and approve these bylaws at their meeting during CSM.

- F. At end of each three (3) year period: SIG funding, policies, and practices will be reassessed for impact on the Section. Modifications will be made as needed.

II. BUDGET

- A. \$5,000 SIG (current SIGs are Occupational Health, Foot and Ankle, Pain Management, Performing Arts, and Animal)
 - Must submit information for a 4 page newsletter in each issue of Orthopaedic Physical Therapy Practice (OP is a quarterly publication).
 - Must hold a Business Meeting for SIG members at CSM each year.
 - Must have bylaws and election of officers in accordance with the Section's bylaw template for SIGs.
- B. Educational Group SIG (current groups are Patellofemoral, Orthopaedic PTA, and Manual Therapy)
 - Will offer programming at CSM each year and may schedule an informational meeting if desired.
 - Will not have a separate budget or separate bylaws within the Orthopaedic Section.
 - Chair will receive travel and one day lodging/meals to CSM for planning and moderating SIG programming at CSM.

III. POLICIES

- A. Each SIG will appear in the Section budget as a program and be managed

in the same manner as other budgetary programs of the Section. The Section office will reimburse budgeted expenses with proper documentation. Copies of the expenses paid will be sent to SIG Treasurers monthly.

- B. SIG budgets shall be submitted for Finance Committee consideration by May 1 of each year. Compliance to SIG policies shall be the responsibility of the SIG. Compliance to Section policies will be monitored by the Finance Committee with the projects and figures adjusted to assure compliance.
- C. All SIG finances shall be managed and controlled through the Section office with the Executive Director and Section Treasurer as fiscal administrators.
- D. The SIG will be expected to provide educational programming for the Section in conjunction with the Section Education Program Committee at CSM.
- E. Special projects requiring funds over the budgeted \$5,000 need to be submitted to the Section Board of Directors for approval via a formal written proposal.

Adjournment 6:30 PM

CSM BUSINESS MEETING CALL FOR AGENDA ITEMS

If you have any motions, new business, or agenda items you would like to have discussed at our next business meeting at CSM in February, please e-mail or fax them to the Section office by January 31, 2001.

All items submitted by this date will be addressed at the business meeting in the order they were received. Any items not submitted by the deadline above or any items brought to the floor during the business meeting will be addressed after the items submitted by the deadline, time permitting.

CSM Programming

San Antonio, Texas • February 14-17, 2000

Wednesday, February 14, 2001

TIME	PROGRAM	SPEAKERS
8:00 AM – 5:00 PM	The Paradigm of Physical Therapy and Pain Management in the 21 st Century	Thomas Watson, David Butler, Joseph Kleinkort, John Garzione

Thursday, February 15, 2001

TIME	PROGRAM	SPEAKERS
8:00 AM – 11:00 AM	Multi-Programming – Negotiating Common Ground: Facilitating Patient Adherence in Clinical Practice	Christopher Lorish, Gail Jensen
12:00 PM – 4:40 PM	Research Platform A	
12:00 PM – 4:40 PM	Research Platform B	
12:30 PM – 2:30 PM	External Peer Review: Legal and Professional Issues	Douglas White, Bruce Levine
1:30 PM – 4:30 PM	Pain Management SIG Programming – Integration of Pain Sciences into Clinical Decision Making	David Butler, Russ Foley
2:00 PM – 3:30 PM	Orthopaedic Certified Specialists (OCS) Exam and Description of Advanced Clinical Practice (DACP) – What's the Deal?	Richard Ritter, Joe Godges
3:30 PM – 4:30 PM	ABPTS OCS Update	Mike Cibulka, Nancy Henderson, Robert Johnson

Friday, February 16, 2001

TIME	PROGRAM	SPEAKERS
7:00 AM – 8:00 AM	Public Relations: The Link Between Your Clinic and the Public	
7:00 AM – 10:30 AM	JOSPT Editorial Board Meeting	
8:00 AM – 10:30 AM	The Older Weekend Warrior: Preventing and Treating Injuries for the Active Older Adult	
8:30 AM – 10:00 AM	Clinical Residency Program Credentialing: Forum and Working Roundtables	Jay Irrgang, Joe Godges, Marcia Stalvey
8:30 AM – 10:30 AM	Research Platforms A	
8:30 AM – 10:30 AM	Research Platforms B	
8:30 AM – 9:50 AM	Case Study Presentations	
9:00 AM – 10:30 AM	Examination and Treatment for the Shoulder Girdle: An Integration of Preferred Practice Patterns Using the Guide to Physical Therapist Practice	Brian Tovin, Bruce Greenfield
12:30 PM – 2:30 PM	Manuscript Reviewer Workshop	
12:30 PM – 3:30 PM	PTA SIG Programming – Osteoarthritis Management in the Elderly	Steve Tippett, Mark Richards
12:30 PM – 4:30 PM	Manual Therapy: Curriculum Issues for First-Professional Faculty	Trish King, Anthony Delitto, Stanley Paris, Susan Appling, Dave Johnson, Steve McDavitt
12:30 PM – 4:30 PM	<i>Performing Arts SIG Programming</i>	
12:30 – 1:30	New Perspective on Etiology, Evaluation, and Management of Patients with Signs and Symptoms of Chronic Pain and Cumulative Trauma Disorder	Peter Edgelow
1:30 – 2:30	Creative Movement for Pain Relief	Barrett Dorko
2:30 – 3:00	The Use of High Intensity Noxious Electrical Stimulation for Pain Control in the Performing Arts Patient Population	Tara Jo Manal
3:00 – 3:30	Development and Implementation of a Dance Screening Tool	Mark Erickson
3:30 – 4:00	Effects of Mobilization of Fourth Thoracic Vertebra (T4) on Pain and Hand Skin Temperature in Adult Women with Complex Regional Pain Syndrome	Susan Stralka
4:00 – 4:30	Upper Quarter Pain and Dysfunction in the Versatile Musician: A Case Study Application of an Outcome Measure	Amanda Whitehead
12:30 PM – 4:30 PM	<i>Occupational Health SIG Programming</i>	
12:30 – 2:15	OSHA Ergonomic Standards: Status Update and Review	Susan Munroe
2:25 – 2:30	OSHA – Compliance Assistance as a Resource	Joann Natarajan
2:30 – 4:30	Hot Topics: Should there be an Ergonomic /Occupational Health Certification for PT's	Ken Harwood

12:30 PM – 4:30 PM	<i>Foot and Ankle SIG Programming – Management of Lower Extremity Injuries in Runners</i>	
12:30 – 1:30	Biomechanics and Pathomechanics of Running Injuries	Blaise Williams
1:30 – 2:30	Treatment Guidelines for the Injured Runner	Melissa Hatley
2:30 – 3:30	Footwear Considerations for the Injured Runner	Thomas McPoil
3:30 – 4:30	Patient Case Presentations: The Injured Runner	Irene McClay
2:30 PM – 4:30 PM	Meeting the Challenge of the Culturally Diverse and Underserved Populations: educational, community, institutional and organizational	Jill Black, Gail Jensen, Diane Corman, Kim Nixon-Cave
4:30 PM – 5:30 PM	Animal Physical Therapist SIG Business Meeting	
4:30 PM – 5:30 PM	Manual Therapy Roundtable Business Meeting	
4:30 PM – 5:30 PM	Foot and Ankle SIG Business Meeting	
3:30 PM – 4:30 PM	PTA SIG Business Meeting	
4:30 PM – 5:30 PM	Performing Arts SIG Business Meeting	
4:30 PM – 5:30 PM	Pain Management SIG Business Meeting	
4:30 PM – 6:00 PM	Occupational Health SIG Business Meeting	
6:30 PM – 7:30 PM	Meet the JOSPT Editor and Editorial Board: Question and Answer Forum	

Saturday, February 17, 2001

TIME	PROGRAM	SPEAKERS
8:30 AM – 10:30 AM	Orthopaedic Section Business Meeting	
12:30 AM – 2:30 AM	Surgical Interventions and Physical Therapy Implications for Bony Metastasis	Marianne Egan, Troy Barry
12:30 PM – 2:30 PM	Book Reviewer Workshop	
12:30 PM – 2:30 PM	Research Platform A	
12:30 PM – 2:30 PM	Research Platform B	
12:30 PM – 3:30 PM	Manual Therapy Roundtable Programming – Modern Imaging and Clinical Correlation in Patients with Spinal Pain	Charles Aprill
12:30 PM – 4:30 PM	<i>Animal Physical Therapist SIG Programming</i>	
12:30 – 12:50	Introduction to Comparative Anatomy and Physiology (room A)	Kristinn Heinrichs
12:50 – 2:15	Introduction to Equine Anatomy and Physiology (room A)	Arlene White
12:50- 2:15	Introduction to Canine Anatomy and Biomechanics (room B)	Cheryl Riegger-Krugh
2:15-3:30	Equine Rehabilitation Case Studies (room A)	
3:30 – 4:30	Canine Rehabilitation Case Studies (room B)	
1:00 PM – 4:30 PM	Clinical Kinesiology of the Wrist and Hand	Teri Bielefeld, Donald Neumann
1:30 PM – 4:30 PM	Patellofemoral SIG Programming	
1:30 – 2:00	Is the VMO an Automatically Distinct Structure?	John Hubbard
2:00 – 2:30	The Use of EMG for Studying VMO Function: What Can It Tell Us?	Greg Karst
2:30 – 3:00	The Relationship Between VMO Activity and Patellar Tracking	Christopher Powers
3:00 – 3:30	Clinical Perspectives Regarding the VMO: Integrating Research into Practice	Jim Zachazewski
2:30 PM- 3:00 PM	Rose Research Platform	
6:30 PM – 8:00 PM	Awards Ceremony	
8:00 PM – 11:00 PM	Black Tie and Roses Reception	

Sunday, February 18, 2001

TIME	PROGRAM	SPEAKERS
8:00 AM – 12:00 PM	Occupational Health Board of Directors Meeting	
8:30 AM – 11:30 AM	<i>Adhesive Capsulitis: New Concepts in Treatment of the Shoulder</i>	
8:30 – 9:00	Anatomy of the Glenohumeral	David Boyce
9:00 – 11:00	Pathogenesis, Evaluation and Treatment of Adhesive Capsulitis	Jeff Placzek
11:00 – 11:30	Legal Issues and Generating Referrals	Paul Roubal

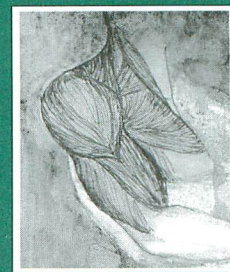
HOME STUDY



COURSE

Solutions to Shoulder Disorders

An Independent Study Course
Designed for Individual Continuing Education



Topics and Authors

- 11.1.1 **Functional Shoulder Anatomy and Biomechanics** *Paula M. Ludewig, PT, PhD*
- 11.1.2 **Physical Diagnostic Tests of the Shoulder: An Evidence-based Perspective** *John Tomberlin, PT, MPhty St (manip), OCS, CSCS*
- 11.1.3 **Relationship of Overuse, Impingement, and Subtle Hypomobility and Hypermobility** *Walter L. Jenkins, PT, MS, ATC*
- 11.1.4 **Rotator Cuff Disorders** *Marie A. Johanson, PT, MS, OCS*
- 11.1.5 **Relationship Between the Shoulder and the Cervicothoracic Spine** *Kim Dunleavy, PT, MS, MOMT, OCS*
- 11.1.6 **Frozen Shoulder** *Kevin Farrell, PT, PhD, OCS*

Editorial Staff

Carolyn Wadsworth, PT, MS, OCS, CHT, Editor Ted Kepros, MPT, Subject Matter Expert

Course Description

This well-balanced course gives you a credible source of information on shoulder disorders. Extremely knowledgeable authors with an array of backgrounds explore the biomechanics and interactions of the multi-joint shoulder complex. You will learn how to correct imbalance of key structures to enhance function and prevent disability. You also will discover the most valid tests to use in differential diagnosis. Take advantage of this unique opportunity to improve your skills in examining and managing the shoulder.

Continuing Education Credit

Thirty contact hours will be awarded to registrants who successfully complete the final examination. Registrants must apply to their individual State Licensure Boards for approval of continuing education credit.

Registration Fees*

Register now! First monograph available in January 2001.

- \$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.

11.1 Solutions to Shoulder Disorders

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
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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





The Orthopaedic Section, APTA, Inc.
and the
Pain Management SIG, Orthopaedic Section
proudly present:

“The Paradigm of Pain in the 21st Century”

February 14, 2001
20001 Combined Sections Meeting * Preconference Course
San Antonio, Texas

COURSE OUTLINE:

Wednesday, February 14, 2001

8:00 - 9:00	Paradigm of Pain and Physiology of Pain
9:00 - 12:00	Mobilization of the Nervous System
12:00 - 1:15	LUNCH
1:15 - 2:15	ASTM and Industrial Rehabilitation
2:15 - 3:45	Electrotherapy—Iontophoresis, Electrical Nerve Blocks and Transcranial Microcurrent Theory and Application
3:45 - 4:00	BREAK
4:00 - 5:00	Alternative Approaches to Pain—Magnets, Lasers, Nutritional Supplements, Future Modalities/ Procedures Q & A

SPEAKERS:

David Butler, PT
Russell Foley, PT

John Garzione, PT, AAPM
Joe Kleinkort, PT, MA, PhD

Tom Watson, PT, MEd, FAAPM

TUITION:

	Early Bird (prior to 12/18/00)	Advanced (prior to 1/15/01)	On-Site
Orthopaedic Section PT Members:	\$150.00	\$200.00	\$225.00
Orthopaedic Section PTA Members:	\$125.00	\$175.00	\$200.00
APTA PT Members:	\$205.00	\$255.00	\$280.00
APTA PTA Members:	\$165.00	\$215.00	\$265.00
Non- Members:	\$225.00	\$275.00	\$325.00
Orthopaedic Section Student Members:	\$ 35.00	\$ 75.00	\$115.00
APTA Student Members:	\$ 45.00	\$ 85.00	\$125.00
Student Non-Members:	\$ 90.00	\$140.00	\$165.00

CANCELLATION POLICY:

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

Sign up early and learn about PAIN and how to treat it from the panel of experts

How to Register: Contact APTA's Service Center at 800.999.2782 x 3395 for details on registering
Questions about the course? Contact Tom Watson, President of the PAIN SIG: 760.796.6787
Or Stefanie Snyder at the Orthopaedic Section office: 800.444.3982





ORTHOPAEDIC SECTION, APTA, INC.

Call for Applicants:

HOME STUDY COURSE EDITOR

The Orthopaedic Section of the American Physical Therapy Association is looking for a top-notch physical therapist to manage the editorial content of its home study course series in order to produce quality, professional monographs. The home study course editor exercises control over the editorial content of each monograph. A professional background in writing as well as a professional background in publications is preferred. Additional responsibilities include:

- Developing topic areas for new courses as well as individual monographs within each course
- Promoting the submission of monographs
- Obtaining authors for each monograph
- Determining mutually agreed upon deadlines for submission of all monographs between the author, editor, and managing editor
- Reviewing all monographs and sending revisions back for review
- Making all final decisions regarding acceptance or rejection of monographs
- Maintaining and enhancing the review process for all monographs with the managing editor
- Responding to phone/e-mail inquiries from authors and course registrants regarding monographs
- General correspondence

The Home Study Course Editor will be directly responsible to the Managing Editor and Executive Director. The editor will also work closely with the Home Study Course Coordinator on a daily basis.

Interested individuals should send a current curriculum vitae and three professional references along with a summary of your qualifications and your ideas on what you would like to develop within a home study course program to:

Terri DeFlorian, Executive Director
Orthopaedic Section, APTA, Inc.
2920 East Avenue South, Suite 200
La Crosse, WI 54601
tdeflorian@centurytel.net

Deadline for application submission is FEBRUARY 18, 2001.



CONTINUE YOUR EDUCATION

Through a Home Study Course



The Orthopaedic Section, APTA, Inc. offers excellent continuing education through its Home Study Course Series

History

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

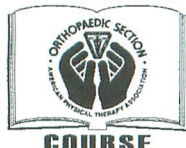
Each home study course includes 6 monographs and a binder to hold the course materials. Each monograph averages 20-28 pages in length and requires 4 to 6 hours to complete. All monographs contain 10 self assessment multiple-choice questions (answers are on the last page). Upon completion of the course, 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 examination within 4 weeks of receiving the final monograph. For completed courses, registrants receive all 6 monographs and must return the examination within 90 days.

Continuing Education Credit

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

HOME STUDY



COURSE



Completed Courses Currently Available

- 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
- HSC 10.1 Basic Science for Animal Physical Therapists
- HSC 10.2 Orthopedic Interventions for Pediatric Patients
- HSC 10.3 Contemporary Topics on the Foot & Ankle

2001 Courses

- HSC 10.4 Disorders of the Knee (October 2000-March 2001)
- HSC 11.1 Solutions to Shoulder Disorders
- HSC 11.2 Current Concepts of Orthopedic Physical Therapy
(This is an 11 monograph course. Contact the Section office for details and fees.)

2002 Courses

- HSC 12.1 Prosthetics & Orthotics
- HSC 12.2 Orthopedic Interventions for Selected Disorders

Registration Fees

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

(Wisconsin residents add sales tax.)

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 course.

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

REGISTRATION FORM

Course # _____ APTA # _____

Name _____

Credentials _____

Address _____

City _____ State _____ Zip _____

Daytime Phone _____

E-Mail Address _____



Please check: Orthopaedic Section Member
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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)
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Fax registration and Visa or MasterCard number to (608)788-3965 or phone toll free (877)766-3452

Visa/MC# _____

Exp. _____ Amount _____

Signature _____

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

2001 Poster and Platform Presentations

NOTE: You will find the complete abstracts in the January 2001 issue of the *Journal of Orthopaedic and Sports Physical Therapy*.

POSTER PRESENTATIONS

Thomas J. Bishop
Primary Prevention in the Workplace: Current Practice

Dennis L. Cade
The Relationship Between Pelvis Tilt and Iliopsoas, Rectus Femoris, and Hamstring Muscle Lengths

Dennis L. Cade
Indirectly Measuring Length of the Iliotibial Band and Related Hip Structures: A Correlational Analysis of Four Hip Adduction Tests

Ming-Shun Cheng
Physical Therapy and Health Outcomes in Patients With Work-Related Upper Extremity Disorders

Cynthia M. Chiarello
The Relationship Between Anterior Tibial Translation and The Phases of the Menstrual Cycle: A Comparison Between Oral Contraceptive Users and Nonusers

Susan A. Chinworth
Frequency of Documentation in Individuals Treated For Knee Pathology in an Outpatient Setting

David D. Ebaugh
Scapular Kinematics During Active and Passive Arm Elevation

Nancy Gann
A Comparison of Physical Therapy Students With and Without Instructions in Ultrasound Pressure Applications

Caryn S. Grogan
The Prevalence of Occupational Musculoskeletal Injuries Reported By Physical Therapists (PT's) in Home Health, Acute Care and Outpatient Rehabilitation Settings

Michael O. Harris-Love
Correlation and Reliability of Anaerobic Fatigue Indices in Healthy Adults Performing Maximal Isometric Elbow Flexion

David Kohns
Clinical and Functional Outcomes of Patients Receiving Rotator Cuff Repair and Rehabilitation

Ya-Ling M. Lai
A Descriptive Analysis of Acute Post-Operative Physical Therapy Management of Patients Following Hip Fracture

David F. Levine
The Effect of Static Magnetic Fields on Grip Strength: A Double Blind Study

David J. Miller
Effect of Workstation Position on Thoracic Erector Spinae Muscle Activity and Perceived Comfort

Carla Pereira
Application of the Guide to Clinical Practice: A Retrospective Chart Review

Michael D. Ross
Physical Therapy and Short-Term Functional Outcomes for Patients with Low Back Pain

Kimberly B. Smith
Comparison of One Component of the Health Assessment Questionnaire with the Similar Timed "Get-Up and Go" Functional Outcomes Test

David Tiberio
A Double Blind Placebo Controlled Study of a New Pain-Relieving Patch

David D. Wise
Abdominal/Back Extensor Co-Contraction During Trunk Curl on a Stable Surface vs. Swiss Ball

Thomas R. Nuzum
Two Cases of Atlantoaxial Subluxation

Tracy J. Brudvig
Exertional Rhabdomyolysis:

Would You Be able to Identify This Syndrome?

Ronald F. Bybee
The Training Effect of the Postural Analysis System-1000 on Frequency and Duration of Lumbar Flexion

Mary K. Hastings
Metatarsal Soft Tissue Stiffness in Subjects With and Without Diabetes

Wanda B. Nitsch
Reliability of Three Pectoralis Minor Length Tests

Marie A. Johnson
The Relationships Among Static Forefoot Varus Angle, Standing Calcaneal Position, and Subtalar Pronation During Gait in Subjects with Moderate-to-Large Forefoot Varus Angles

Susan HN Jenó
An Electromyographical Study of Lower Trapezius Muscle Activity During Exercise in Traditional and Modified Positions

Scott A. Musgrave
A Surface Electromyography (SEMG) Assessment of the Posture of Children With and Without a Book Bag Carried on One and Both Shoulders

Cindy H. Gill
The Effects of an Industrial Back Belt on the Biomechanics of Lifting and the Subject's Perception of Security During Lifting

Marcie J. Harris
Treatment of a Patient with Lumbar Extension Syndrome: A Case Report

George C. Maihafer
A Comparison of the Figure-Of-Eight Method and Water Volumetry in Measurement of Swollen Hand and Wrist Size

Gary E. Mattingly
A Method for Measuring Flexion/Extension Resting Position Angle of the Acromioclavicular Joint

Gordon Gonyea
The Effect of Delaying a

Stretch Following Ultrasound Treatment in the Achilles Tendon: Ultrasound and the Stretch Window

William D. O'Dell
The Use of the Coefficient of Variation in Determining Maximal Versus Sub-maximal Effort in Static Strength Testing Performed by an Uninjured Individual

Frank H. Rath
Reliability of the Modified Ober Test

Wanda B. Nitsch
Reliability of Three Pectoralis Minor Length Tests

John T. Cavanaugh
Clinical Competency Program in an Orthopaedic Hospital's Multi-Disciplined Rehabilitation Department

Kyndy L. Boyle
An Interdisciplinary Elective Course on Rehabilitation for Animals for Entry-Level Master of Physical Therapy (MPT) and Doctor of Veterinary Medicine (DVM) Students

Ming-Shun Cheng
Effects of Fatigue on the Mechanics of a Repetitive Knee Exercise in Patient with ACL Reconstruction

Susan C. Guynes
The Intertester and Intratester Reliability of the Inclinator in Measuring Forefoot Position in Relation to the Rearfoot

Ronald J. Schenk
Validity of The Duffy-Rath Questionnaire

Kathryn E. Roach
Development and Reliability of the Miami Back Index

Michael A. O'Hearn
Evaluation and Treatment of a Fibular Stress Fracture in a High School Football Player: A Case Report

Corinne M. Sicola
Dynamic Versus Static Stretching Techniques to Enhance the Height of

- Developpe Front in Classical Ballet Dancers
Theresa M. Spitznagle
Pain in the Sacral Region: A Case Study
- Barbara J. Headley
Trunk Core Stabilization as a Factor in the Reduction of Recurrent Low Back Pain
- Jeannette R. Bull
A Pilot Study Measuring and Evaluating Motor and Verbal Behaviors of Adult Lifting: Instrumentation Development and Videotape Influence
- Andrew L. McDonough
The Concurrent Validity of Observational and Stopwatch Measurement of Walking Time by Physical Therapists
- Alice M. Hodges
The Comparison of Scapular Upward Rotation During A Shoulder Pulley Elevation and an Active Scaption Exercise
- Heather M. Murray
Effect of Kinesio Taping on Proprioception in the Ankle
- Maura F O'Shea
Functional Assessment and Treatment of RSD/CRPS in a Difficult Workers Compensation Case Utilizing an Inpatient Multidisciplinary Pain Management Program
- Paul G. Jenkins
A Taping Technique used to Treat Posterior Tibial Tendonitis in a 17 Year Old Female with Ehlers-Danlos Syndrome
- Carrie Schauer
The Effect of Positional Release Technique on Strength
- Cheryl Reigger-Krugh
Outcome in Knee Osteoarthritis Intervention with Use of the Anodyne System and Synvisc: A Case Study
- Caroline P. Adamson
Monochromatic Infrared Photo Energy (MIPE) in the Intervention of a Bilateral Delayed Union Followed by Ulnar Osteotomy in a 2-Year Old Labrador Retriever
- Dawn T. Gulick
Validity of an Alternative
- Underwater Measurement of Body Composition: Bottle Buoyancy
Jon D. Hacke
Reliability of Pelvic Landmark Palpation
- Mary A. Wilmarth
Normative Values of Head Posture and Cervical Spinal Curvature in the Mexican Population
- Elizabeth R. Ikeda
The Effect of Static Magnets on Delayed Onset Muscle Soreness: A Double Blind Study
- Carolyn Kern
The Use of Work Tolerance Assessments as Part of Clinical Evaluation in Determining Work Status Level of the Injured Worker
- Rich D. Maas
The Posterior Relocation Test for the Hip: A Clinical Tool to Differentiate Posterior Hip Functional Instability
- Dana Roberts
The Effects of Static Magnets on Chronic Cervical Pain
- Liv Forberg
The Effect of Foot Position on Maximal Functional Reach Tests
- Kathleen M. Alexander
Postural Taping in the Treatment of Temporomandibular Joint Dysfunction
- Scott D. Davis
Comparison of Intratester and Intertester Reliability in Determining Subtalar Joint Neutral Via Visual Congruency and Palpation of Talar Head in Open and Closed Kinetic Chains
- Gaetano Lombardo
Sources of Error in the Measurement of Rearfoot Angle in Subtalar Joint Neutral
- Angela D. Ohar
Posture Awareness Book Cover for Female Adolescents
- Amanda B. Whitehead
Treatment of the Versatile Musician: A Case Study
- Kelly S. White
Comparative Proprioception
- in Surgically Repaired Unstable Shoulders
Christine M. Torricelli
Changes in Physical Activity of Students During the First Four Months of the Professional Phase of a Physical Therapy Program
- Barbara J. Headley
A Surface Electromyography Assessment of Motor Vehicle Patients and Controls to Establish Presence of Soft-Tissue Injury: A Pilot Study
- PLATFORM PRESENTATIONS THURSDAY**
Session A: 12:00 - 12:20
Jan A. Ryberg
The Effect of Fatigue and Elastic Bandages on Knee Joint Proprioception
- Session A: 12:20 - 12:40
Lisa B. Johnston
The Effect of Three Shoe Wear Conditions on the Lateral Patellar Displacement in Subjects with Anterior Knee Pain
- Session A: 12:40 - 1:00
James W. Matheson
Electromyography and Applied Load During Knee Extension Exercises Using Four Types of Resistance
- Session A: 1:00 - 1:20
Gail D. Deyle
Physical Therapy Treatment Effectiveness for Osteoarthritis of the Knee: A Comparison of Supervised Clinical Exercise and Manual Therapy Procedures Versus a Home Exercise Program
- Session A: 1:20 - 1:40
Katrina S. Maluf
Effect of Tendon Achilles Lengthening on Gait Characteristics in Patients with Diabetes Mellitus
- Session A: 1:40 - 2:00
Michael J. Mueller
Effect of Tendon Achilles Lengthening on Muscle Performance Characteristics in Patients with Diabetes Mellitus
- Session A: 2:00 - 2:20
Peter J. McNair
Viscoelastic Behaviors and Proprioception After Achilles Tendon Rupture
- Session A: 2:20 - 2:40
Mary E. Carlson
Leg Length Differences in Lateral Patellofemoral Pain Syndrome
- Session A: 2:40 - 3:00
Todd M. Gage
Anterior Tibial Tendon Ruptures: Results of Surgical Treatment
- Session A: 3:00 - 3:20
Scott Holman
The Accuracy of Flat-Foot and Heel-Off Unilateral Partial Weightbearing During Bilateral Upright Stance
- Session A: 3:20 - 3:40
Mary K. Allen
Relationship Between the Static Measure of First Ray Mobility and First Ray, Midfoot and Hindfoot Motion During the Stance Phase of Gait
- Session A: 3:40 - 4:00
Rob Roy L. Martin
Development of the Foot and Ankle Ability Measure (FAAM): Item Reduction Based on Factor Analysis and Item Response Theory
- Session A: 4:00 - 4:20
Christopher M. Powers
Comparison of Foot Pronation and Lower Extremity Rotation in Persons With and Without Patellofemoral Pain
- Session A: 4:20 - 4:40
Barbara A. Springer
A Prospective Study of Modified Ottawa Ankle Rules in a Military Population
- Session B: 12:00 - 12:20
Nancy E. Quick
Evaluation of the Upper Limb Tension Test Using Nerve Conduction Velocity and Surface Electromyography in Healthy Adults
- Session B: 12:20 - 12:40
Michael T. Gross
Efficacy of Semi-rigid Foot Orthotics for Plantar Fasciitis
- Session B: 12:40 - 1:00
Jason D. Handschumacher
Prevention of Soft Tissue Injury During Vigorous Physical Activity: A Meta-Analysis
- Session B: 1:00 - 1:20
Joseph A. Threlkeld
Effect of Varying Levels of

Body Weight Suspension on the Kinematics of Treadmill Walking at 125 CM/Sec

Session B: 1:20 - 1:40

Mark W. Cornwall
Three-Dimensional Movement of the First Ray During Normal Walking

Session B: 1:40 - 2:00

Julie A. Reo
Effects of Four Different Modes of Instruction on Learning an Upper Extremity Exercise Program

Session B: 2:00 - 2:20

Robert S. Wainner
Reliability of Common Clinical Examination Measures for Cervical Radiculopathy and Carpal Tunnel Syndrome and the Diagnostic Accuracy of the Clinical Examination and Self-Report Instruments for Carpal Tunnel Syndrome

Session B: 2:20 - 2:40

John S. Schmitt
Validity and Reliability of the Disabilities of the Arm, Shoulder, and Hand (DASH) Functional Outcome Measure

Session B: 2:40 - 3:00

Mia L. Erickson
The Effects of Closed Versus Surgical Reduction and Smoking on Outcome After Distal Radius Fracture

Session B: 3:00 - 3:20

Sharon S. Wang
The Effect of the McConnell Shoulder Taping Technique on People with Anterior Shoulder Pain

Session B: 3:20 - 3:40

Tina Jabali
Development of a Shoulder Endurance Test: Assessment of Measurement Properties in Healthy Individuals

Session B: 3:40 - 4:00

Robert Donatelli
Using Static Progressive Stretch (SPS) and Stress Relaxation (SR) in the Treatment of Glenohumeral Joint Adhesive Capsulitis

Session B: 4:00 - 4:20

Dawn M. Cox
Validity of the Modified Isometric Stability Test in Measuring Changes in Pelvic Motion Associated with Stabilization Exercises

Session B: 4:20 - 4:40

Gerard P. Brennan
Functional Outcomes of Patients Following Lumbar Fusion with "Ray Cages"

FRIDAY

Session A: 8:30 - 8:50

Darlene M. Santner
The Effect of Cervical Retraction Exercise on Functional Reach Test Scores, Cervical Range of Motion, and Forward Head Posture in Female Geriatric Subjects

Session A: 8:50 - 9:10

Bo Daniel Parr
Cervical Dysfunction and Balance: A Comparison of Cervical Patients and Normals

Session A: 9:10 - 9:30

Steven Z. George
The Comparison of Fear-Avoidance Beliefs in Patients with Cervical and Lumbar Pain

Session A: 9:30 - 9:50

Mary Ellen Bulow
Determining the Accuracy of a New Device that Measures Reposition Sense in the Thoracolumbar Spine

Session A: 9:50 - 10:10

Julie Joiner
A Descriptive Study of the Use of Spinal Extension Measurement Techniques

Session A: 10:10 - 10:30

Timothy W. Flynn
Characteristics of Patients with Low Back Pain Who Respond Best to Sacroiliac Region Manipulation

Session B: 8:30 - 8:50

Rhonda L. Pearson
Effect of McKenzie Prone Press-Up Exercise on Lumbar Extension, Pelvic ROM, Stride Length, and Gait Velocity

Session B: 8:50 - 9:10

David M. Selkowitz
Effect of External Support on Surface EMG of the Lumbar Spine During Maintenance of Forward Flexion

Session B: 9:10 - 9:30

Ronald F. Bybee
Lumbar Extension Range of Motion: A Comparison of the Effects of McKenzie Advocated Brief, Frequent, and Repeated Stretching to Static Stretching

Session B: 9:30 - 9:50

Patrick J. Bouley
Intrarater and Interrater Reliability with Assessing Accuracy of Exercise Performance of Four Commonly Used Low Back Exercises

Session B: 9:50 - 10:10

John R. Jefferson
The Effect of Cushioning Insoles on Back and Lower Extremity Pain in an Industrial Setting

Session B: 10:10 - 10:30

Julie M. Fritz
Comparison of Classification-Based Treatment Versus a Non-Specific Approach for Subgroups of Patients with Acute Low Back Pain: Subgroup Analysis of a Randomized Clinical Trial

Case Study: 8:30 - 8:50

Matthew B. Garber
Use of Diagnostic Imaging in Differential Diagnosis: Two Case Studies

Case Study: 8:50 - 9:10

Tadeusz Laska
Physical Therapy Case Report for Accessory Nerve Injury Complicated by Adhesive Capsulitis

Case Study: 9:10 - 9:30

Pamela J. Leerar
Differential Diagnosis of Tarsal Coalition Versus Cuboid Syndrome in an Adolescent Athlete

Case Study: 9:30 - 9:50

J. B. Barr
Exploration of Novice Clinical Reasoning: A Case on Non-Musculoskeletal Thoracic Pain

SATURDAY

Session A: 12:30 - 12:50

John D. MacGillivray
A 3-D Analysis of the Golf Swing: Implications for the Total Hip Arthroplasty Patient

Session A: 12:50 - 1:10

Robert W. Schrepfer
The Relationship Between Patient Numeric Global Rating and Three Region Specific Outcome Measures

Session A: 1:10 - 1:30

Nancy Gann
The Study of Pressure Norms for Physical Therapists When Applying Ultrasound

Session A: 1:30 - 1:50

Jeanna E. Fulenwider
Soft Tissue Tension Detection Via Palpation Differs in Physical Therapists and Physical Therapy Students

Session A: 1:50 - 2:10

Dennis L. Hart
Development of an Index of Functional Health Status

Session A: 2:10 - 2:30

Lynn A. Maguire
Effects of Work Injury Prevention Program for Housekeeping in the Hotel Casino Industry

Session B: 12:30 - 12:50

Stephen J. Hunter
Using Functional Improvements to Promote Active Therapy and Determine Length of Treatment of Workers Compensation Patients. A 3-Year Analysis of 63,000 Claims

Session B: 12:50 - 1:10

Deborah G. Heiss
The Effect of Practice Schedule on Lifting Unexpected Loads

Session B: 1:10 - 1:30

Dawn T. Gulick
Effect of Ultrasound on Pain Associated with Myofascial Trigger Points

Session B: 1:30 - 1:50

Deanna R. Hayes
A Quality of Life Outcomes Comparison of Multidisciplinary Pain Management and Conventional Unimodal Treatment for Chronic Pain

Session B: 1:50 - 2:10

Gilbert M. Willett
Preferential Activation of Specific Abdominal Muscles During the Curl-Up Exercise

Session B: 2:10 - 2:30

Peter J. McNair
Electromyographic Activity of Abdominal Musculature During Walking

Section News

PRACTICE COMMITTEE REPORT

At the Fall Board of Directors Meeting, October 6-7 in LaCrosse, WI the Practice Committee presented 2 practice related motions and worked with the other committees and the Board of Directors (BOD) to upgrade the Orthopaedic Section strategic plan. The motions and pertinent information presented and passed by the Orthopaedic BOD are detailed below. More will be forth coming on the strategic plan from President Boissonnault and at CSM.

The following practice motions were submitted and passed at the Fall Orthopaedic Section BOD meeting:

1. *It is the position of the Orthopaedic Section, APTA, Inc. that Orthopaedic Section continuing education opportunities be available to participants outside the profession of physical therapy and that related credentialing for all participants be consistent in the areas of content, goals and objectives in accordance with the Guide to Physical Therapist Practice and the Normative Models of Physical Therapist and Physical Therapist Assistant Education. Professionals, other than physical therapists, or paraprofessionals may participate in cognitive components (learning) but not participate in the psychomotor (laboratory experiences) components unless validated within the practice scope of their profession.*

SS: This position is to clarify any confusion in offering Orthopaedic Section, APTA, Inc. continuing education courses or distribution of related materials to those other than physical therapists and provide definition parameters for credentialing offered to other professional or paraprofessional participants.

2. *It is the position of the Orthopaedic Section, APTA, Inc. that mobilization and manipulation be defined as:*

Mobilization/manipulation: a manual therapy technique comprised of a continuum of skilled passive movements to joints and/or related soft tissues that are applied at varying speeds and amplitudes, including a small amplitude/high velocity therapeutic movement.

SS: Manipulation and mobilization are terms used interchangeably and synonymously in various historical descriptions and within schools of manipulative treatment to describe and imply a variety of manual therapy techniques across a spectrum of clinically applied amplitudes and velocities. Manipulation and mobilization terminologies are used interchangeably and synonymously to describe soft tissue mobilization, craniosacral techniques, myofascial release, joint mobilization, joint manipulation, thrust, oscillations, and articulations. These skilled direct interventions are applied in daily common PT practice and are described in various practice patterns and conditions in the *Guide to Physical Therapist Practice* (Manipulation/Mobilization-Patterns 4D1-9).

There is a need to be more specific in operationally defining manipulation and mobilization and the above definition is now (latest edition 2000) used in the glossary of the *Guide to Physical Therapist Practice* for practice pattern management descriptions and for use in describing physical therapy practice, reimbursement, education, research, legislation, and regulation. Combining "manipulation/mobilization" in one definition will provide a more accurate description for the actual eclectic clinical integration and practice of these interventions across the variety of manual therapy indications and techniques described in the physical and manual therapy literature. It will also be consistent with the *Guide to Physical Therapist Practice*.

It is a pleasure to serve the Orthopaedic Section members and executive. We remain a member driven committee and look forward to serving the members' practice needs as they arise.

Stephen McDavitt, PT, MS
Helene Fearon, PT
Co-Chairs Practice Committee

PUBLIC RELATIONS COMMITTEE REPORT

The following is an excerpt from the web site of the American College of Nurse Practitioners, describing last year's conference.

"A unique feature of the symposium was 'The Learning Center,' which opened with ACNP offering exhibitors a course on

cardiopulmonary resuscitation (CPR) presented by the American Heart Association. The Learning Center also featured Terry Randall of the American Physical Therapy Association teaching the musculoskeletal exam of the shoulder and knee with an emphasis on when to refer for physical therapy intervention."

These musculoskeletal clinics were repeated at this year's symposium in Salt Lake City. Thanks to Kim Cohee, PT and Debbie Hein-Helgren, PT for the help in staffing the exhibit booth.

I have talked with Hal Blank, who is the president-elect of the American Society of Orthopaedic Physicians Assistants (ASOPA). They are interested in formalizing a liaison relationship with us to exchange educational opportunities, discuss regulatory issues, and explore other areas of common interest.

Advisory Panel on Public Relations

The APTA advisory Panel on Public Relations met on June 23-24. The purpose was to review our strategic plan and make recommendations to the board on changes in our PR plan. Other members of the panel are Phil Tygiel and Judy Sebring. A significant change in the scope of the APTA's PR campaign has been recommended. The emphasis on consumer advertising has been changed. In the past few years an average of \$900,000 was spent on consumer advertising. Our advertising will now be focused on the groups which restrict our practice such as insurers, purchasers, and legislators. The consumer will continue to be targeted with a public relations campaign which is much cheaper than direct advertising. The third target audience that has been added is our members. Increasing membership, satisfaction, and awareness regarding their responsibilities as professionals, are some of the goals. More emphasis will be placed on the development of 'PR kits' and other materials that can be used by our members with their own advertising and media events. I think these changes will have a positive impact on the membership of the Orthopaedic Section. Our next meeting will be in February and should result in training and the production of specific promo-

tional materials that can be used by components.

Check out our new website at www.orthopt.org! Please try out the bulletin board and let us know what other information you would like to see posted on the site.

Terry Randall, PT, OCS

Public Relations Committee Report

NOMINATING COMMITTEE REPORT

1. The Nominating Committee is pleased to announce the following slate of nominees for the election this fall:

PRESIDENT

Stephen C. F. McDavitt, PT, MS

Michael T. Cibulka, PT, MHS, OCS

VICE PRESIDENT

Lola Rosenbaum, PT, MHS, OCS

NOMINATING COMMITTEE

Tom McPoil, PT, PhD, ATC

Timothy W. Flynn, PT, PhD, OCS,

FAAOMPT

Spencer David Blackie, PT, OTR,

MTC, OCS

2. The Nominating Committee communicated with additional potential candidates who declined to run for various reasons or asked to be considered at a later date. The names of these individuals along with all pertinent information will be kept on an electronic database at the Orthopaedic Section office.

3. The statements for all candidates will be posted on the Orthopaedic Section web page.

4. The Orthopaedic Section very much appreciates the willingness of members to run for office. We also want to thank members for taking the time to vote during this election year.

5. Please feel free to contact any member of the Nominating Committee or the Orthopaedic Section at any time if you are interested in running or if you know someone who is interested in running for office.

*Mary Ann Wilmarth, PT, MS, OCS, MTC,
Cert. MDT*

Chair, Nominating Committee

(Continued from page 14)

in the future. Negligent care should be referred to your supervisor in the insurance company for action. Do not be afraid to continue to follow-up on the decision of action. If nothing takes place, contact the Chapter office for a peer reviewer to contact that facility for a proposed visit. Due to your confidentiality clause you signed with the insurance company to do claim reviews, you would have to have management's approval (in writing is better) to refer this case to the state licensure board.

If you have further questions on these processes, contact APTA's Office of Reimbursement at 800/999-2782 ext. 8511 or me.

Carolyn Bloom, PT is President of the Health Policy Legislation Reimbursement Section.

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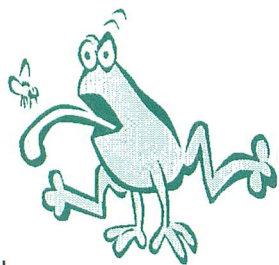


Orthopaedic Physical Therapy
Practice (OP) has recently been
indexed by the
Cumulative Index to Nursing
and
Allied Health Literature
(CINAHL).

We have also obtained an
ISSN number for OP - 1532-0871.

OP continues to grow
because of you - our membership!
*Thank you for your
continued support.*

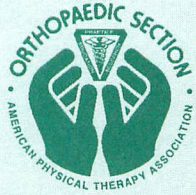
DON'T "FROGET" TO RENEW...



your Orthopaedic Section membership dues with the renewal of your National and Chapter dues. If your dues aren't paid on time, you will have a lapse in your membership, and miss out on some of the Journals, courses, and conferences that the Section offers.

Failing to renew your membership will result in your name being removed from the mailing list, and processing your renewal could take up to 2 months.





OCCUPATIONAL HEALTH
PHYSICAL THERAPISTS
SPECIAL INTEREST GROUP



ORTHOPAEDIC SECTION, APTA, INC.

Winter 2000

Volume 12, Number 4

Y2K and Beyond: Where are we Headed?

Our Board of Directors has just completed its fall retreat outside lovely Burlington, Vermont. We had hoped for crystal blue skies, crisp fall air, and some color. Instead we got rain, clouds, delayed flights, and green trees.... But all was not lost! We accomplished some terrific work and shared the opening ceremonies of the 2000 Olympics, some good food, and some healthy laughter.

Most of all I was inspired and excited by some of the new ideas and the revitalization of old ideas for our 2001 - 2003 strategic plan. Here are the highlights:

Goal 1: Administration: Ensure that the regular business of the OHPTSIG occurs efficiently and effectively.

a. We plan to continue to meet 3 times a year: at CSM, Annual Conference, and Fall retreat, with quarterly phone conferences in between. The additional meeting times have been extremely beneficial in keeping us all on task. We are working well together and accomplishing our goals!

b. Bonnie Sussman, our Treasurer, plans to review and revise our policy and procedures manual as needed by CSM 2001.

Goal 2: Communication and Public Relations: Facilitate communication between OHSIG BOD and membership and between OHSIG and other components of APTA and external organizations.

a. We are continuing to submit articles through OPTP as well as advertise our upcoming CSM and Annual Conference events.

b. We would like to update and expand our page on the Orthopaedic Section web site.

c. We plan to reinstate our membership questionnaire, which will give us feedback from the membership regarding educational programming and other ways we may best serve the membership. We would like to post this questionnaire on our web page.

d. We plan to increase active participation on our committees by 25% and our general membership by 10%.

e. We want to add a social component after our business meeting to promote opportunities for members to network with each other and meet the BOD.

Goal 3: Research: To promote and disseminate research that is essential for physical therapists to practice safely and effectively within the realm of occupational health.

a. An exciting new initiative is that the OHSIG would like to cosponsor (perhaps in conjunction with the Research Section, the Orthopaedic Section, and the APTA Department of Research) a retreat or a series of conferences on Research in Topics Re-

lated to Occupational Health Physical Therapy. The purpose of such a conference would be to have presenters review the literature on different aspects of OHPT practice, determine the gaps in our existing knowledge, and hold focus groups to develop some OHPT research priorities that could be submitted to the Foundation for development into RFPs. We will look to the Orthopaedic and Research Sections for guidance and direction as we further develop this concept.

b. We will continue to encourage the presentation of OHPT research at CSM.

Goal 4: Education: Contribute to the professional development of physical therapists providing services within the realm of occupational health.

a. We have a very timely presentation planned by a representative from OSHA on the proposed Ergonomic Standards. The presenter will update us regarding the status of the guidelines and the impact on physical therapy if they are passed. She will also discuss the utilization of the literature supporting the guidelines for prevention services.

b. We are considering a format for our educational programming at CSM that would involve preconference workshops with the regular CSM programming expanding on one aspect of the preconference programming.

Goal 5: Practice: Promote professional practice and encourage appropriate reimbursement in occupational health physical therapy.

a. We are in the process of revising the Ergonomic and Legal and Risk Management Guidelines. When these are complete, we will publish in a compendium and establish a process for periodic updating.

b. We are exploring options for developing a certification process and/or clinical competencies in Ergonomics or Occupational Health. Our hot topics forum at CSM will offer an opportunity for members to provide input and discuss this issue.

c. In conjunction with APTA's office of practice, we are developing an official response to the Department of Labor's request for input on O*NET. The O*NET content model and OMB clearance package will be circulated to selected members for response regarding O*NET and its database.

Should There Be an Ergonomic/Occupational Health Certification for PTs?

Make sure your voice is heard as this *hot topic* is discussed Friday, February 16 at 2:30. Immediately following is our Business Meeting and Social Hour at 4:30. Feed us your input, fill your mind with knowledge, and satiate your palate with refreshments. All are invited!

Needs Assessment Survey
Occupational Health Special Interest Group, Orthopedic Section, APTA, Inc.

1. What is your primary employment setting? (Choose one)
 - a) Hospital
 - b) Out-patient facility associated with a hospital
 - c) Private Practice
 - d) Academic
 - e) On-site clinic in the workplace
 - f) Consultant
 - g) Other:

2. Is your position primarily:
 - a) Clinical
 - b) Administrative/Management
 - c) Teaching
 - d) Research
 - e) Student

3. What percent of your practice activity is related to prevention or treatment of work-related injuries? (Choose one.)
 - a) 100% d) 49 - 25%
 - b) 99 - 75%
 - c) 74 - 50%
 - e) less than 25%

4. What occupational health services does your facility/practice offer? (Choose all that apply.)
 - a) Evaluation and treatment of the acutely injured worker
 - b) FCE
 - c) Job Demands Analysis
 - d) Hazard Identification and Modification
 - e) Work Conditioning
 - f) Work Simulation
 - g) Work Hardening
 - h) Developing transitional duty programs
 - i) Post-offer screening
 - j) Other:_____

5. What type of industry does your practice serve?
 - a) Construction
 - b) Manufacturing
 - c) Office environment
 - d) Service
 - e) Other:

6. Years experience in Occupational Health Physical Therapy:
 - a) less than 5
 - b) 6 - 10
 - c) 11 - 20
 - d) greater than 20

7. Gender: Male Female

8. Highest level of education:
 - a) Bachelor
 - b) Master
 - c) Doctorate
 - d) Associate (PTA)

9. Are you a Board Certified Orthopaedic Clinical Specialist (OCS)?

Yes No

10. If no to # 9, why not?
 - a) Have other specialist certifications
 - b) Working on an academic degree instead
 - c) Lack of time to prepare
 - d) Too expensive
 - e) Lack of eligibility in accumulated hours of experience
 - f) Lack of eligibility in current practice hours in orthopaedics
 - g) No perceived benefit to me
 - h) Have tried but failed test
 - i) Don't feel the certification is an accurate measure of competency
 - j) Other:_____

11. Do you have an ergonomics certification from:
 - a) BCPE
 - b) Oxford Institute
 - c) Other:

12. If no, why not?
 - a) Working on an academic degree instead
 - b) Lack of time to prepare
 - c) Too expensive
 - d) Lack of eligibility in accumulated hours of experience
 - e) Lack of eligibility in current practice hours
 - f) No perceived benefit to me
 - g) Have tried but failed test
 - h) Don't feel the certification is an accurate measure of competency
 - i) Unaware of certification process
 - j) Other:_____

13. Do you have an interest in pursuing a specialization/certification related to Occupational Health Physical Therapy through the APTA?

Yes No

14. If the answer to number 8 is yes, would you prefer:
 - a) A specialization/certification in Occupational Health Physical Therapy
 - b) A specialization/certification in Ergonomics
 - c) Other:_____

15. If the answer to number 8 is no, why not?

16. What is the maximum you would be willing to pay for the certification/specialization?
 - a) less than \$500
 - b) \$500 - \$1000
 - c) \$1000 - \$2000
 - d) Greater than \$2000

Contact Information for the OHSIG BOD

PRESIDENT

Deborah Lechner, PT, MS
ErgoScience, Inc
4131 Cliff Rd
Birmingham, AL 35222
Ph: 205 595-4536
Fx: 205 592-9528
Email: deborahlechner@ergoscience.com

VICE PRESIDENT

Bonnie Sussman, PT, MEd
Cioffredi & Associates Physical Therapy
PO Box 727
Lebanon, NH 03766
Ph: 603 643-7788
Fx: 603 643-0022
Email: bsussman@tpk.net

TREASURER

Mark Blankenspoor, PT
1316 N Prairie St
Pella, IA 50219-1383
Ph: 515 621-0230
Fx: 515 621-0319
Email: worksystems@lisco.com

SECRETARY

Michael House, PT, MS
901 Lincoln St
Wray, CO 80758
Ph: 970 332-3471
Fx: 970 332-3487
Email: mhouse1@plainstel.com

PRACTICE & REIMBURSEMENT

Darcy Higgins, PT, MS
Spectrum Therapy Greene
8584 Seminole Trail
Ruckersville, VA 22968
Ph: 804 985-2288
Fx: 804 985-6909
Email: dhiggins@spectrumtherapy.com

RESEARCH

Scott Minor, PT, PhD
Washington University School of Medicine
Campus Box 8502
4444 Forest Park Blvd
St. Louis, MO 63108
Ph: 314 286-1432
Fx: 314 286-1410
Email: minors@msnotes.wustl.edu

EDUCATION

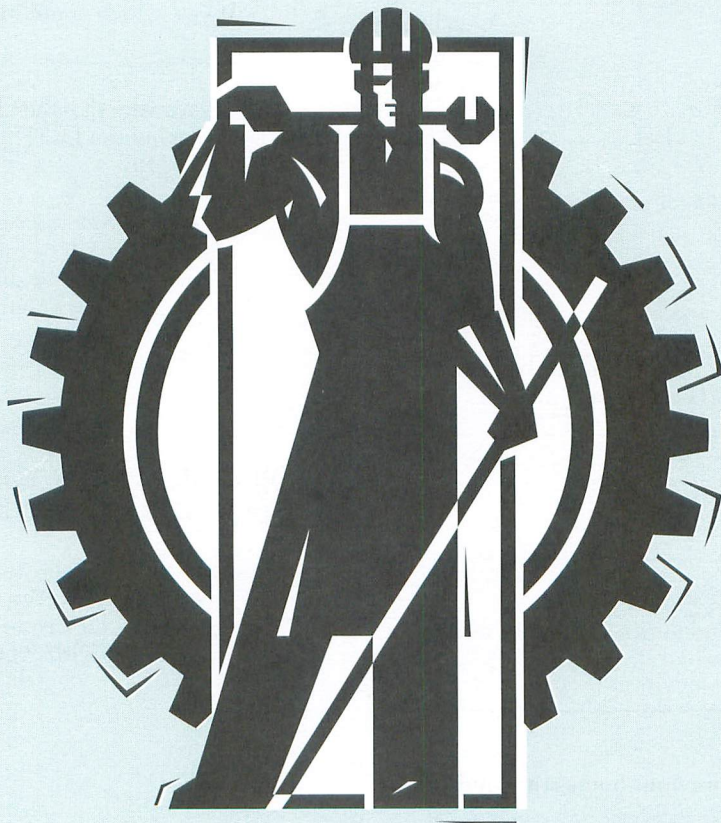
Ray Vigil, PT, OCS
Body Mechanix Physical Therapy
6810 N. Broadway, Suite C
Denver, CO 80221-2849
Ph: 303 428-0866
Fx: 303 428-0511
Email: Vigil7777@aol.com

NOMINATING

Kenneth J. Harwood, PT, MA, CIE
Columbia University
710 West 168th St, 8th Fl
New York, NY 10032
Ph: 212 305-1649
Fx: 212 305-4569
Email: kh111@columbia.edu

MEMBERSHIP

Steve Allison, PT, MHS
Tri-State Physical Therapy, Inc.
South Park Medical Plaza
2120 Bert Kouns, Suite B
Shreveport, LA 71118
Ph: (318) 687-4156
Fax: (318) 687-9755
e-mail: occfit@shreve.net



FOOT *f* ANKLE

SPECIAL INTEREST GROUP ORTHOPAEDIC SECTION, APTA, INC.

Greetings Everyone!

I hope this finds each of you well! As always the Foot & Ankle Special Interest Group has been extremely active since I last communicated with you in *Orthopaedic Practice*.

- The first Foot and Ankle Special Interest Group Research Retreat entitled "Static and Dynamic Classification of the Foot," was held at the Historic Inns in Annapolis, MD on May 19-20, 2000. Thirty (30) participants that included registrants from both Canada and Australia attended the meeting. The group was made up of podiatrists, physical therapists, biomechanists, and footwear specialists, all with an interest in foot and ankle research. The objective of the retreat was to examine the area of static and dynamic classification of the foot through the presentation of research findings with the mission of developing a consensus regarding future research directions. *All of the participants expressed that they felt the meeting was a great success.* Much of the success of the meeting can be attributed to the hard work of Irene McClay as well as Stefanie Snyder and Tara Fredrickson. As FASIG President, I want to express my sincere appreciation for all of their hard work in making this first retreat such a success. Irene has completed editing the abstracts as well as an outcome summary of the retreat that will be published in upcoming issue of JOSPT. The outcomes of the retreat included:

- That classification should occur along a continuum rather than grouping into distinct foot type categories. It was agreed that classification should lead to the ability to develop valid and reliable functional assessment tools and determine clinically relevant functional outcomes, and that future studies should be focused in this direction.
- That an accessible database be established so that data could be shared and compared among clinicians and researchers. In order to facilitate this, standardization of terminology regarding foot mechanics is needed so that common semantics will be used across disciplines

Topics for future research retreats were discussed and a number of suggestions were made including the aging foot, evidence-based outcomes, modeling of the foot (both inverse and forward dynamic models), and mechanisms behind orthotic intervention. It is hoped that the FASIG could sponsor another retreat in 2 years.

- Unfortunately because of poor projected attendance, the planned 2½-day Foot & Ankle Seminar (similar to the successful preinstructional course held prior to CSM in New Or-

leans) which was to be held at Rush-St. Luke's Medical Center Physical Therapy Department in Chicago, IL, in October had to be cancelled. This was the last of one of this type of course that the FASIG had planned to present. At this time, the course is not scheduled to be presented again, but Mark Cornwall and I will consult with the Education Committee at CSM in San Antonio in regards to possible future directions.

- Over 119 members of the Foot & Ankle Special Interest Group responded to the survey that was sent to all registered members. With the help of both Tara Fredrickson and Stefanie Snyder, the returned FASIG surveys are being sent to Steve Reischl, Chair of the Survey Subcommittee, in order to tabulate the results. The purpose of the survey was to establish a database of those physical therapists currently providing various levels of foot and ankle care as well as to gain insight into the number of FASIG members actively involved in providing foot and ankle services. The FASIG membership approved the distribution of the survey at the Business Meeting at the New Orleans CSM. As promised, the results of the survey will be presented to the membership at our Business Meeting at CSM in San Antonio.

- The FASIG continues to serve as a resource to not only Orthopaedic Section members but to APTA members as well. This past year the FASIG responded to approximately 100 inquiries from physical therapists and nontherapists via email or telephone regarding the management of various foot and ankle disorders.

- Mark Cornwall, FASIG Vice President, has planned an excellent FASIG educational session for the upcoming CSM in San Antonio, TX. The theme of the session is running injuries and will feature 4, 1-hour presentations on both running mechanics, and mechanisms of injury, as well as management through the use of case presentations. This topic was suggested by several FASIG members at last year's CSM Business Meeting. The FASIG educational session will take place on Friday afternoon from 12:30 to 4:30 p.m. Topics include: The Biomechanics and Pathomechanics of Running Injuries, Treatment



Guidelines for the Injured Runner, Footwear Considerations for the Runner, and Patient Case Presentations – The Injured Runner. Speakers include: Blaise Williams, PT, PhD; Melissa Hatley, PT; and Irene McClay, PT, PhD. This years educational program promises to be both timely as well as stimulating and I look forward to seeing you at the session on Friday afternoon.

- The FASIG will hold its annual Business Meeting at the 2000 CSM in San Antonio, TX, following the FASIG education session. The Business Meeting is scheduled to start at 5:00 p.m. and will last no longer than 1 hour. In addition to our discussion of old and new business, elections will be held for President, Secretary-Treasurer, and Nominating Committee. I would like to encourage you to consider running for any of these three positions. If you are interested, please contact Steve Paulseth, Nominating Committee Chair (310-286-0447) or me so that we can place your name on the ballot.

In closing, I encourage all of you with and interest in the foot and ankle to become actively involved in the Foot & Ankle Special Interest Group. The success of our Foot & Ankle SIG is directly related to the involvement of Orthopaedic Section members such as you! If you have any questions, suggestions, or comments regarding the Foot & Ankle Special Interest Group, please do not hesitate to contact me.

*Best Regards as Always,
Tom McPoil*

FOOT & ANKLE OFFICER LISTING

CHAIR:

Tom McPoil, PT, PhD, ATC	(520) 523-1499
Northern Arizona University	(520) 523-9289 FAX
Dept of Physical Therapy	tom.mcpoil@nau.edu
NAU Box 15105	
Flagstaff, AZ 86011	

VICE CHAIR:

Mark Cornwall, PT, PhD, CPed	(520) 523-1606
Northern Arizona University	(520) 523-9289 FAX
Dept of Physical Therapy	mark.cornwall@nau.edu
NAU Box 15105	
Flagstaff, AZ 86011	

SECRETARY/TREASURER:

David S Sims, Jr., PT	(540) 869-6675
101 Cotswold Court	(540) 665-5530 FAX
Stephens City, VA 22655-3403	dsims@su.edu

RESEARCH/NOMINATING CHAIR:

Stephen G Paulseth, PT, MS	(310) 286-0447
2040 Ave of the Stars Ste P104	(310) 286-1224
Los Angeles, CA 90067-4708	paulsethpt@earthlink.net

PRACTICE CHAIR:

Joe Tomaro, PT, MS, ATC	(412) 321-2151
490 East North Ave, Suite 501	(412) 434-4909 FAX
Pittsburgh, PA 15212	tomaro@dug3.cc.edu



Performing Arts Special Interest Group • Orthopaedic Section, APTA

MESSAGE FROM THE PRESIDENT

Greetings to you all. It is hard to believe that CSM 2001 is right around the corner, but February is not that far away. I hope that many of you will attend the exciting programming that we have planned. Nick Quarrier has worked very hard to design programming in response to membership feedback. In addition to 2 great speakers, Peter Edgelow and Barrett Dorko, we are excited to present our annual Shop Talk and Dialogues in Performing Arts Research workshops.

The PASIG is continuing to grow and change – we are electing a new Vice President, Secretary, and member of the Nominating Committee at CSM. If you are interested in participating in the SIG, we welcome your energy and ideas. Please send your nominations to Amy Wightman at abwightman@hotmail.com. This year we would also like to identify Regional Directors for the PASIG. Regional Directors would serve as a point of contact for the Executive Board to help bring local performing arts therapy events to national attention, and to generate grass roots involvement with the PASIG. If you have any questions, comments, or interest in becoming a Regional Director, please contact me at Jenn526@aol.com.

Finally, a note regarding the SIG's practice analysis—we have laid out a budget and timeline for completing this project and applied to the Orthopaedic Section office for funding. As of this writing, we have tentative verbal approval of our budget and have commenced forming a National Advisory Group of content experts to help guide our development of a description of performing arts physical therapy. We will undoubtedly be contacting all of you to provide input for defining our practice area, and we look forward to sharing this process with you in more detail at our Business Meeting at CSM.

See you all in February 2001!!

*Sincerely,
Jennifer M. Gamboa, MPT*

COMBINED SECTIONS MEETING 2001 PASIG PROGRAMMING

The PASIG is planning an exciting and informative CSM 2001 educational program, which will take place on Friday, February 16, 2001 in the afternoon session at 12:30 PM. Details follow:

Presentations (1 hour each):

New Perspective On The Etiology, Evaluation and Management of Patients With Signs and Symptoms of Chronic Pain and Cumulative Trauma Disorder

Speaker: Peter I. Edgelow, MA, PT

Creative Movement For Pain Relief

Speaker: Barrett L. Dorko, PT will discuss and demonstrate the use of Simple Contact to elicit both corrective and creative movement.

Shop Talk (30 minutes each):

A PASIG programming innovation! An open forum for discussion and demonstration of practical aspects of the physical therapy care of performing artists.

The Use of High Intensity Noxious Electrical Stimulation for Pain Control in the Performing Arts Patient Population

Speaker: Tara Jo Manal, PT, MPT, OCS

Development and Implementation of a Dance Screening Tool

Speaker: Mark R. Erickson, PT, MA will include discussion of preliminary common findings with dancers, and intervention strategies to address common impairments.

Dialogues in Performing Arts Research:

This is an annual PASIG event, in which novice researchers have the opportunity to receive feedback from an expert panel of researchers, who review and critique their projects. These discussions provide a wonderful forum to explore and refine the research process, and have already fueled new research among our members.

Distinguished Panel: Nancy Byl, PT, PhD

Linda Van Dillen, PT, PhD

Katherine Roach, PT, PhD

Effects of Mobilization of Fourth Thoracic Vertebra (T4) on Pain and Hand Skin Temperature in Adult Women With Complex Regional Pain Syndrome

Speaker: Susan W. Stralka, PT, MS

Upper Quarter Pain and Dysfunction in the Versatile Musician: A Case Study Application of an Outcome Measure

Speaker: Amanda Brooks Whitehead, SPT

PASIG Business Meeting: Following the PASIG programming. Find out what's happening in your SIG by attending this meeting!

Reception: After the business meeting, PASIG members and guests are all invited to adjourn to a local saloon for fun, conversation, and maybe even "a little night music!"

LAST CALL FOR NOMINATIONS!

This Fall, we are nominating candidates for Vice President, Secretary, and Nominating Committee member. Are you good leadership material, or do you know another PASIG member who is? Do you feel your interests reflect those of your fellow members? Then perhaps you would like to run for PASIG office! Following is a brief outline of the responsibilities of these offices and the guidelines for nominations. All terms of office are 3 years.

Vice-President: Member of the Executive Board. Chair of the Education Committee, which committee is responsible for developing and arranging CSM programming.

Secretary: Member of the Executive Board. Records minutes of PASIG meetings and Executive Board meetings; carries out official correspondence of behalf of the PASIG and on behalf of the Executive Board to the PASIG membership; coordinates Membership Directory updates; produces PASIG Newsletter for the *OPTP* quarterly.

Nominating Committee Member: One of 3 committee members. Assists Nominating Committee Chair to network among the PASIG membership and help develop candidates for office who display leadership interest and qualities. Assists in overseeing of the PASIG election process. A new Nominating Committee member is elected yearly, and in the last year of the term assumes the Chairperson position.

NOMINATION GUIDELINES: Nominees must be PASIG members, therefore also Orthopaedic Section members. Further, nominees must give their consent to be nominated before their names may be put forward. Nominees may be self-nominated. Nominees' names should be submitted to Amy Wightman, Nominating Committee Chair, by e-mail at abwightman@hotmail.com or by phone (860) 643-3562. Nominees should be prepared to provide a brief Biography and a Candidate Statement describing their goals for the office for which they are nominated.

DEADLINE FOR NOMINATIONS IS 12/31/00. If you would like to find out more, please contact Amy Wightman for more information.

Elections will be held by a vote at the CSM 2001.

MEMBERSHIP NOTICE

Your PASIG membership is not automatically renewed when you renew your Orthopedic Section membership. If you wish to renew your PASIG membership, you must do so separately. A membership form follows. There is no extra fee for PASIG membership. **Member benefits/privileges:** Members may hold office and vote in PASIG elections, will receive e-mail or mail notices, will be listed in the Membership Directory, and serve as a resource for fellow members or have access to resources through other members. If you have had an address change or have added an e-mail address, be sure to let Donna Ritter (PASIG Secretary) know by email at drpt@airmail.net, phone 214-892-0049 (VM/pager), or by mail to: Pitman Creek Physical Therapy, 700 Alma, Suite 135, Plano, TX 75075.

Name: _____
Address: _____
City, State, Zip: _____
Home Ph: (____) _____
Business Ph: (____) _____
Email: _____

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
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GLOSSARIES	\$ 2.00

TO ORDER: Call the Orthopaedic Section today at 1-800-444-3982.

All proceeds go to the PASIG.



PASIG EXECUTIVE COMMITTEE

President: Jennifer M. Gamboa, MPT
w: 703-527-9557
fax: 703-526-0438
e-mail: JENN526@AOL.COM

Vice-President: Nick Quarrier, PT, MHS, OCS
w: 607-274-3053
fax: 608-274-1137
e-mail: NQUARRIE@ITHACA.EDU

Treasurer: Jeff Stenback, PT, OCS
w: 305-595-9425
fax: 305-595-8492
e-mail: jsptocs@aol.com

Secretary: Donna Ritter, PT
w: 972-424-5840
fax: 972-423-9427
page/VM: 214-892-0049
e-mail: drpt@airmail.net

Past President: Brent Anderson, PT, OCS
w: 305-284-4534
e-mail: baudbo@newsson.med.miami.edu

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Chair: w: 860-643-3562
e-mail: abwightman@hotmail.com

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Pain MANAGEMENT

SPECIAL INTEREST GROUP • ORTHOPAEDIC SECTION, APTA, INC.

The Paradigm of Pain in the 21st Century

The number 1 complaint in any physician's office is pain, most commonly musculoskeletal pain. Over \$250 billion was spent in 1999 for the management and treatment of musculoskeletal pain. Recent surveys show that 89% of adults experience pain at least once a month. Forty-six percent of women and 37% of men experience some type of pain daily. The most common type of pain is joint pain. Backaches and muscle pain were next followed by arthritis. Now 9 of 10 Americans believe alternative medicine can offer significant relief of their symptoms.

The United Nations, World Health Organization, and 22 countries have declared the years 2000- 2010 as "The Bone and Joint Decade." New diagnostic techniques, new interventions, and new medications will be developed for the treatment of musculoskeletal pain. Blended medicine is becoming the new paradigm for the 21st century.

What are we as physical therapists going to do? Is pain a problem? What is blended medicine? Are there new hands on techniques? Will industrial rehabilitation help? Does electrotherapy work? Are nutritional supplements beneficial or dangerous? Do magnets or lasers work?

"The Paradigm of Pain in the 21st Century," a preconference course for CSM 2001 in San Antonio should provide answers to many of these questions.

Don't miss out on the exciting new interventions for treating acute or chronic pain. Don't be left behind.

Tom Watson, PT, MEð, FAAPM
President Pain SIG

Alternative Treatments for Arthritis

Arthritis sufferers spend over \$1 billion a year on unproven remedies for relief of their pain and symptoms. These treatments include copper bracelets, honey, bee stings, vinegar/apple supplements, DMSO, and elimination diets, as well as lasers, biofeedback, magnets, fish oil, yucca plants, and snake venom. None of these treatments are based upon scientific research, but only on anecdotal responses. DMSO, snake venom, and megavitamins can be very dangerous to your health.

Glucosamine and chondroitin sulfate have been used by veterinarians for years to treat arthritis in horses and other large animals. The supplements have been derived from crab, lobster, or clam shells and cow tracheas. It is estimated that approximately 5 million people per year try this supplement for relief of their symptoms. It now appears the anecdotal results have

given rise to a new investigation by the NIH to begin a \$10 million research project involving 1500 patients to look at the 2 supplements individually and when combined together for relief of pain and treating the underlying arthritis.

In an article published this month in the journal, *Osteoarthritis and Cartilage*, the lead author suggested that treatment within the supplement was more effective than a placebo for the treatment of pain and movement in 93 patients with arthritic knees. Another study involved 34 Navy personnel with knee and back pain. The effects on back pain were unclear but the study found knee aching was relieved.

Does this stuff actually work and is it effective? The American College of Rheumatology, suggested on its website that glucosamine can slow cartilage breakdown. Another source states glucosamine can stimulate cells that produce cartilage. Dr. Robert Schenk, Associate Professor and Deputy Department Chairman of Orthopedics at the University of Texas Health Sciences Center San Antonio believes this can have a significant effect. He suggests glucosamine may ultimately be shown to *have chondroprotective qualities*. Chondroitin sulfate may block the enzymes that breakdown old cartilage.

Many orthopedists are recommending the use of glucosamine and chondroitin sulfate for their patients. There are contraindications including pregnancy, diabetes, or concurrent use of blood thinning drugs. Another consideration is cost, which is approximately \$1 per day for 8 weeks.

The anecdotal responses I receive from my patients range from complete relief of symptoms to no help at all. So what's the answer? Let's hope the study by the NIH will give us some answers.

REFERENCES

Minneapolis Star Tribune, Sunday, Oct. 8, 2000, Health page E5
www.discoveryhealth.com/EMDSCOOO/9071/9219.HTML
Orthopedic Technology Review, Volume 1, No. 1, April/May 1999 page 14

Tom Watson, PT, MEð, FAAPM

DON'T BE A PAIN

Join the Pain Special Interest Group and feel the relief of being part of a group of pain guys and gals. New blood is needed but it won't hurt. Call the Orthopaedic Section and join today.

Come to the Pain SIG Business Meeting at the CSM in San Antonio and get the scoop.

Animal Physical Therapist



SPECIAL INTEREST GROUP Orthopaedic Section, APTA, Inc.



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Cheryl Riegger-Krugh, PT, ScD
Physical Therapy Program
C-244 4200 E. Ninth Ave
University of Colorado
Health Sciences Center
Denver, CO 80262
Work: 303-372-9141
Fax: 303-372-9016
E-mail: cheryl.riegger-krugh@uchsc.edu

Vice President and International Liaison

David Levine, PT, PhD
Department of Physical Therapy
University of Tennessee at Chattanooga
615 McCallie Avenue
Chattanooga, TN 37403
Work: 423-755-5240
Fax: 423-785-2215
E-mail: david-levine@utc.edu

Treasurer

Nancy Murphy, PT
PO Box 6586
Ketchum, ID 83340
Home: 208-788-9215
Work: 208-622-6930
E-mail: nmurphy@svidaho.net

Secretary and Public Relations Coordinator

(Newsletter, Logo, Brochure)
Stephanie Fagin, PT
6540 Emigration Canyon
Salt Lake City, UT 84108
Work: 801-231-2543
E-mail: steph.jsilver@aros.net

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Arlene White, PT
6343-2 Riverwalk Lane
Jupiter, FL 33458
Home/Fax: 561-575-0735
E-mail: ArlyFAMU96@aol.com

Education Chair

Kristinn Heinrichs, PT-SCS, PhD, ATC,
CSCS
P.O. Box 3411
Greensboro, NC 27402
Phone: 336-574-3184
E-mail: kheinrichs@estone.net
E-mail: www.sportperformance.org

State Liaison Coordinator

Siri Hamilton, PT, LVT
University of Tennessee College of
Veterinary Medicine
Dept. of Small Animal Clinical Services
2407 River Drive
Knoxville, TN 37901-1071
Work: 865-974-2993
E-mail: sirivtpt@utk.edu

Nominations Committee

Nancy Snyder, PT
15 Pine Street
Grove Town, PA
Home: 724-794-1097
E-mail: nls5580@sru.edu

PTA Representative

Missy Folta, PTA
1436 Preserve Drive
Virginia Beach, VA 23451
Home: 757-428-6645
Work: 757-425-6234
Fax: 757-425-7016
E-mail: Beechboy@GR8brdg.net

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Work: 203-265-1975

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Genoa, NY 13071-9741
Home: 315-497-0333
FAX: 315-497-1461
lin@envisage1.com

CALENDAR OF EVENTS:

- The home study course **BASIC SCIENCE FOR ANIMAL PHYSICAL THERAPISTS** is still available. Contact 800-444-3982 or 608-788-3982 for more information.
- The Combined Sections Meeting (CSM) for 2001 is scheduled for February 15th - 18th in San Antonio, Texas. The Animal Physical Therapist SIG will present a 4-hour session on animal physical therapy.
- The 2nd International Symposium on Rehabilitation and Physical Therapy in Veterinary Medicine will be hosted by the University of Tennessee College of Veterinary Medicine and the University of Tennessee at Chattanooga, Graduate Program in Physical Therapy. It is scheduled for August 2002. To get on the mailing list either send an e-mail to: Conferences@utk.edu or call (865) 974-0280.

THE ANIMAL PHYSICAL THERAPIST (ANIMAL PT) SIG UPDATE:

1. Orthopaedic Section Member and Nonmember directories are available for \$2 through the Section Office 800-444-3982 Fax: 608-788-3965 or Email: ssnyder@centurytel.net.
2. State Liaisons: To date there are 33 states that have Animal Physical Therapist SIG Liaisons. Contact Siri Hamilton for further information at 865-974-2993 or e-mail: sirivtpt@utk.edu
3. In response to a request from Tom Howell, President of the Idaho Chapter, we want to clarify the Idaho's State Practice Act. Tom Howell, PT, contacted us regarding an error printed in the last issue of the Animal PT SIG Newsletter Volume 12;3:00 State Practice Act's terminology listed for Idaho should state that the PT Practice Act includes the words "human beings" in its terminology. The proposed practice act revision, that hopes to pass in 2001, calls to eliminate the words "human beings" and to replace with the word "individuals." The intent, however will not change. The Idaho Veterinary Practice Act was revised in 2000. Chapter 54-2104 states that "...however the chapter shall not be construed to prohibit: (q) An allied health professional actively licensed and in good standing in any state from participating in a medical procedure involving an animal provided that such participation is in his licensed field of medicine and under the indirect supervision of an actively licensed veterinarian."
4. The APTA has a web site that lists all of the State Practice Acts. Go to: www.apta.org/advocacy/state/state-practice.

FREQUENTLY ASKED QUESTIONS (FAQ)

Frequently Asked Question Number 2

1. I'm interested in doing animal therapy. What does animal therapy mean? What are the options for me to get involved as a physical therapist?

The term therapy can mean different things to different people. The term animal therapy can mean therapy provided for animals with pathology or it can mean animals used as part of the intervention for humans with pathology. In the former example, therapy can mean physical therapy, massage therapy separate from the rest of physical therapy, etc. If you are discussing animal physical therapy or physical therapy provided for animals, there are a number of issues to keep in mind related to state practice acts and what you are calling the service you provide. Since a number of physical therapy state practice acts state that the term physical therapy can be applied legally only to humans, we recommend that you call the service you provide physical rehabilitation for animals. Presently, the replacement of "patient or client" for "human" is being considered in a number of state practice acts; however, this wording does not exist in most physical therapy state practice acts at this time. Even if this wording were adopted, physical therapists should seek the knowledge base and skill needed to apply their expertise to any specific animal population. This knowledge base and skill includes the anatomy, biomechanics, and physiology of the specific animal, common injuries and pathologies, and relevant animal behavior, among other areas. While we believe that a physical therapist should be able to acknowledge their credentials as a physical therapist, we recommend that they not call or try to bill their services as physical therapy. We strongly believe that physical therapists, as having expertise in rehabilitation, collaborate with veterinarians, who have the expertise needed for treating the animal as a patient.

In the latter example, animals are used as a therapeutic intervention in treating children with movement disorders (for example, hippotherapy or therapeutic riding programs), law enforcement, assisting individuals with disabilities (service dogs, seeing-eye guide dogs), or at-risk youth/elderly in nursing homes, who have had limited contact with animals (for example, to teach responsibility, compassion for living creatures, provide companionship, and sensory stimulation). For these "working" animals, there are often specific criteria the animals must meet in order to be selected as an appropriate candidate for the job.

The focus for the Animal Physical Therapist Special Interest Group is the provision of examination, evaluation, and rehabilitation intervention and management of neuromusculoskeletal disorders in the animal. Current research by members of the special interest group focuses on the effects of physical rehabilitation intervention for the animal. The animal patients may be competitive athletes or may have suffered neuromusculoskeletal injuries. The goal is to return the animal to the highest functional level possible to meet the goals of the owner and the potential for the animal.

2. Where can I get more information about hippotherapy or pet-assisted therapy programs?

The Delta Society www.delta.org

National Association for Riding for the Handicapped Association (NARHA) www.narha.org
1-800-369-7433

3. Are there any criteria for animals used in therapeutic programs?

Many well-intentioned horse owners donate retired horses to therapeutic riding programs. However, not all of these animals are well suited to therapeutic riding programs. The development and selection of an appropriate horse for therapeutic riding programs is addressed in an excellent book by Jan Spink, MS, titled *Standards and Competencies for the Therapy Horse*. For more information about the use of animals in therapeutic programs, contact the Delta Society, The Assistance Dog Institute, or the North American Hippotherapy Association 1-800-369-7433.

Report from the Animal PT SIG for the Fall Board of Directors Meeting, October 2000

Submitted by: Cheryl Riegger-Krugh ScD, PT
President, Animal Physical Therapist SIG
Orthopaedic Section, APTA

The main issues of interest for the SIG are outlined below.

Credentialing Process for the Animal PT SIG

A credentialing process is a significant interest and focus for the SIG. Physical therapists who want to provide rehabilitation care for animals are requesting this for preparation and documentation of expertise. Veterinarians, with whom these physical therapists are collaborating, and reimbursement agencies are requesting this as proof of documented clinical expertise.

Credentialing for this area of practice will be unique. It involves establishment of a knowledge base in anatomy and biomechanics applied to the animal of interest, animal behavior, understanding of a scientific rationale for different pathologies, etc. While the majority of practice at present is orthopaedic, practice exists for neurological pathology and medical conditions. The Orthopaedic Section encourages development of the scope of clinical practice as the first step in the credentialing process.

Programming at CSM

A 4-hour program has been planned for CSM. This program includes general animal information, equine anatomy and physiology, canine anatomy and biomechanics, and equine and canine case study reports. The case study format includes a scientific approach with the request of outcome measures for animal patients.

Clinical Practice Experiences for Physical Therapists

Several clinical education or residency experiences have taken place this year. One has included one week of clinical affiliation time provided within the framework of a hu-

man professional level master's degree in physical therapy. The release from 1 week of affiliation time with human patients was provided but the affiliation did not count toward the degree. Other pilot residencies have included designated on site collaboration of a graduate PT interested in working with a physical therapist who is treating animals. The requests for clinical affiliations and residencies far outweighs the ability to offer these experiences at present.

Research

For research involving rehabilitation for animals, the SIG is encouraging use of outcome measures in intervention, as well as use of language used in the *Guide to Physical Therapist Practice*.

The SIG also is encouraging use of meaningful outcomes, ie, outcomes that have meaning for the functional limitations and disabilities of the animal. At this time PTs are encouraged to document outcomes for case studies as well as for studies with larger numbers of animals.

State Liaisons

Presently, there are liaisons in 33 states. Siri Hamilton is the new State Liaison Coordinator. There has been a request to establish a committee composed of state liaison members for the purpose of coordinating and standardizing efforts toward legalization of physical therapy practice for animals. This will be investigated with the State Liaison Coordinator.

Resource Manual

Currently, a resource manual exists for physical therapists interested in providing rehabilitation care for animals. It is available directly from Lin McGonagle. Her contact information is included with the officers.

International Veterinary Physical Therapy Organization

Exploration of having an international organization is being coordinated by the SIG Vice President, David Levine. Six nations must have met specific criteria before organization. Presently, there are not 6 nations meeting the criteria.

Orthopaedic Section Membership

PTs interested in this field of practice are encouraged to join the APTA and the Orthopaedic Section. For the cost to purchase the official publication of the Orthopaedic Section called *Orthopaedic Physical Therapy Practice*, a PT who is a member of the APTA could join the Orthopaedic Section and therefore become a full member of the SIG at no extra cost.

Documentation of the Historical Development of Veterinary or Animal PT

Interviews with Ann Downer, PT and Jan Richardson, PT, PhD are planned to help in documenting the history.

Other accomplishments:

- Lin McGonagle, the past president of the SIG, has graduated from veterinary technician school. She will be able to advise the SIG as to how holding dual training and degrees might affect ability to practice.
- A new committee has been formed. The Malpractice Insurance Committee will be chaired by Lin McGonagle, MSPT, LVT.
- A Canine One course occurred in Knoxville, TN and Denver, CO. Canine Two and Equine One courses are being planned.

COMBINED SECTIONS MEETING - SAN ANTONIO, TEXAS FEBRUARY 15-18, 2000

The Animal PT SIG will be conducting a 4-hour informative program during the Combined Section Meeting.

Session 1 Comparative Anatomy and Physiology - Kristinn Heinrichs (20 min)

- Orientation Differences: What are the differences between studying human and veterinary anatomy and physiology?
- Anatomic reference and description (planes, terminology – eg, thoracic and pelvic).
- Bipedal vs. quadrupedal.
- Anatomic differences between human and canine and human and equine.
- Physiologic differences between human and canine and human and equine.

Objectives:

1. Participants will have an appreciation for the basic and general differences between human and veterinary comparative anatomy.
2. Participants will be able to develop an introductory framework for the specific comparative study of the animal (eg, human vs. canine or human vs. equine) to follow in the concurrent sessions.

General considerations for animal study of anatomy and physiology

Session 2A: Introduction to equine anatomy and physiology - Arlene White (concurrent session)(75min)

- Functional anatomy of the thoracic limbs
- Functional anatomy of the pelvic limbs
- Functional anatomy of the spine
- Introduction to unique aspects of equine physiology as it relates to functional anatomy
- Introduction to functional considerations (functional anatomy of the gaits)
- Comments regarding the importance of animal behavior

Objectives:

1. Participants will have an appreciation for the unique characteristics of equine anatomy and how these unique differences relate to the functional characteristics of the horse.
2. Participants will understand the basic principles of the differences between equine and human physiology.
3. Participants will understand the relationship of functional anatomy and physiology to a common pathology (lameness and its possible sources).
4. Participants will have an appreciation of the further study required for competence in the area of equine physical therapy.

Session 2B: Introduction to canine anatomy and biomechanics (concurrent session) (75 minutes Cheryl Riegger-Krugh)

- Functional anatomy of the forelimbs
- Functional anatomy of the hindlimbs
- Functional anatomy of the spine
- Introduction to functional considerations (eg, canine gait)
- Introductory comments on animal behavior (brief and only in context of examples with anatomy)

Objectives:

1. Participants will be able to describe characteristics of canine anatomy from human anatomy and how the differences relate to the function of dogs.
2. Participants will be able to describe some common pathology related to different roles for dogs.
3. Participants will understand and be able to explain why knowledge of canine anatomy is required for physical therapists who want to provide rehabilitation expertise for animals.

**Canine Rehabilitation case study presentations (60 min) -
Equine Rehabilitation case study presentations (60 min)**

A PT's Perspective

by Jerry Smith, PT, MS

I attended a recent state Physical Therapy Association meeting in Florida, which convinced me that physical therapists interested in animal physical therapy should renew and maintain their state memberships. If rehabilitation for animals is ever to become legal in the state of Florida, or any state other than New Mexico, where it is presently legal, it is going to take the voice of the masses to make it so. Less than 3% of the total membership in the Florida Physical Therapy Association were in attendance. This will not do the job! Presidents and Board Members do listen to opinions of their members, slowly perhaps and with much repetition, but they do listen. In August, I expressed my opinion at the state caucus meeting. My concerns for making the practice of physical therapy for animals legal in the state of Florida were expressed, as well as my concern to prevent physical therapists from being fined or having their licenses revoked if treating animals "illegally and thus unethically," as expressed by the Chairman of the Florida Ethics Committee.

Florida is in the process of modernizing its Physical Therapy Practice Act. This is a major political task and requires consideration of many ramifications and consequences. Once the Practice Act is *opened*, this will allow other medically associated professions to question the changes in an attempt to make sure their turf is not being threatened. In Florida, the use of the term "human being" is dominant in the definition of physical therapy. In addition, referral sources, such as physicians, etc... are stipulated. There are differences of opinion among members of the Board of Directors. Should the term "human beings" be omitted and veterinarians be added as a referral source?

Should the mention of all referral sources be omitted? Should mention of all referral sources be omitted as well as reference to "human beings?" This would probably be ideal. However, animal physical therapy is a fledgling profession and an extension of physical therapy practice, and would have difficulty being accepted by veterinarians without the approval of their supervision. Fifty years ago, a major task of the physical therapy profession was convincing physicians that physical therapy had a place in the treatment of their patients. Physical therapists are now at the threshold of proving to another profession that we can help in the care of their patients. The difference is we are being asked by veterinarians to do so. So let's do it! We need their supervision. We are dealing with a different genus and species other than *Homo sapiens*. We cannot treat a "hot horse" fresh off the track with a bowed tendon by ourselves. Behavioral problems make it necessary to have help, tranquilizers, restraints, etc. When treating a horse for other problems, using physical therapy modalities such as ultrasound and electrical stimulation it is necessary to discern what type restraint is necessary. The supervision of a veterinarian is absolutely essential. This kind of supervision is frequently required in the treatment of smaller animals. I cannot recall, throughout the many years of my practice, the necessity of restraining or tranquilizing a patient in order to administer physical therapy modalities. We are dealing with an entirely different species of animal that we are not exposed to during our training as physical therapists. As animal physical therapy progresses, I hope there will be elective courses included in the curriculum of physical therapy schools that will provide exposure to the uniqueness of using physical therapy modalities in the treatment of animals. I am requesting the Boards of Physical Therapy to give physical therapists a chance to show the veterinarians what physical therapy can do for the treatment of their patients and allow them to open the door for collaboration under their necessary supervision.

- If you are a Florida PT who would like to help influence the FPTA to edit their Practice Act to allow PTs to perform physical therapy on animals please write to show your support to:

Mr. Gary Walters, President
Florida Physical Therapy Association
1705 S. Gadsden Street
Tallahassee, FL 32301
Email: Mr.gwalters@worldnet.att.net

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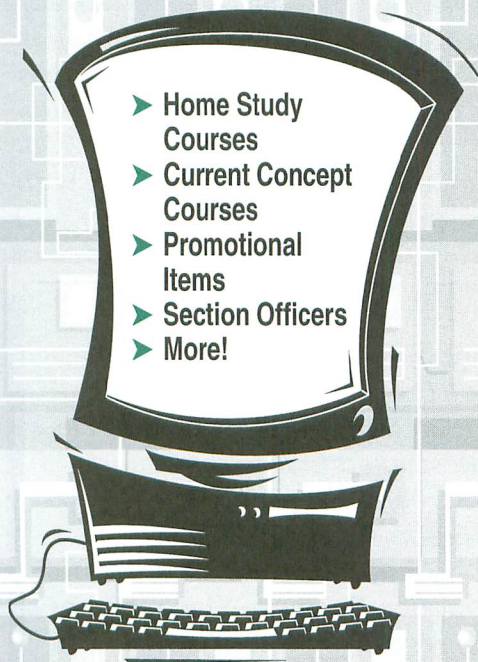
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Orthopaedic Section

HOME PAGE ON THE INTERNET

www.orthopt.org



Remember, you can find us on the World Wide Web. We will continually update the Home Page and will add even more informational items and news about "current" orthopaedic physical therapy practice. In addition we now offer Home Study Course information as well as the table of contents for our Section magazine, Orthopaedic Physical Therapy Practice on our home page. So get on the "NET" and find us! We are "linked" to the American Physical Therapy Association's Home Page (www.apta.org) as well as to the Foot & Ankle SIG, the Occupational Health SIG, the Performing Arts SIG, the Pain Management SIG, and the Animal PT SIG Home Pages.

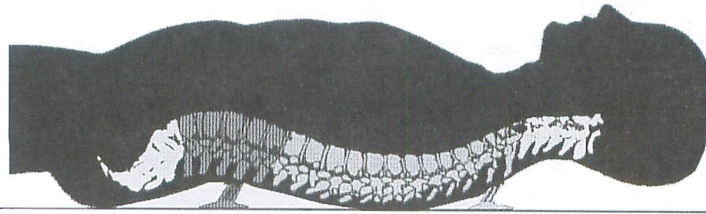
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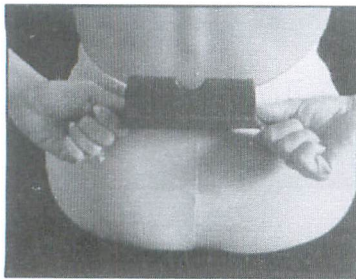
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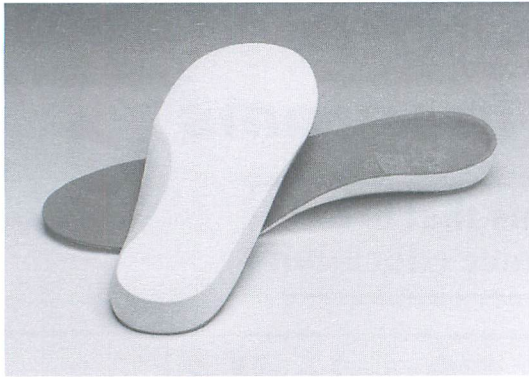
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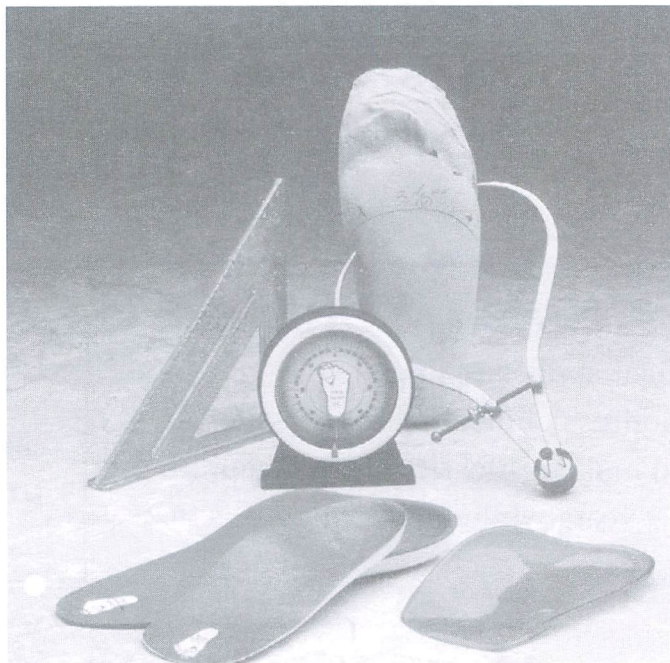
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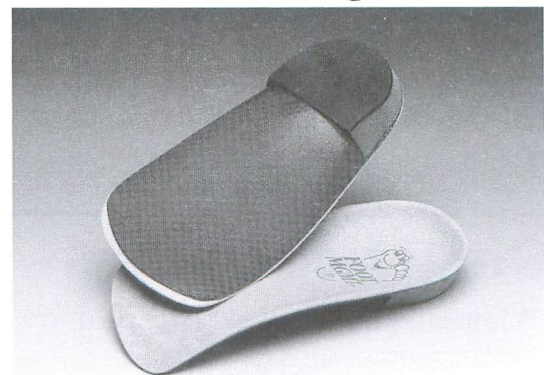
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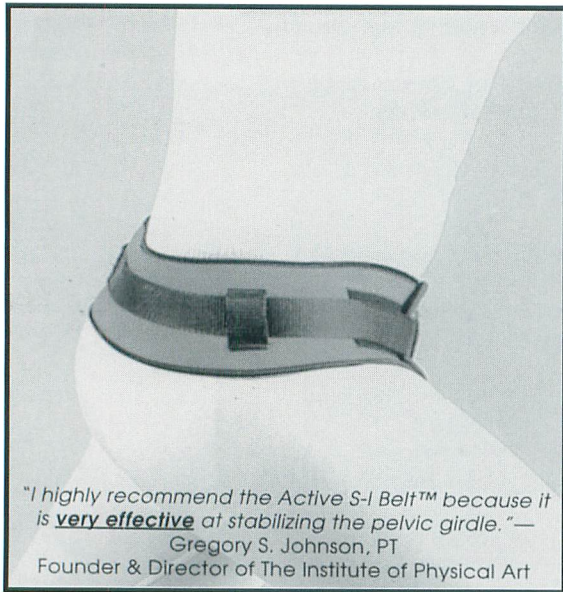
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1. *Orthopaedic Physical Therapy Practice (OPTP)* will publish articles pertaining to clinical practice. Articles describing treatment techniques as well as case studies and reviews of literature are acceptable.
2. Manuscripts should be reports of personal experiences and written as such. Though suggested reading lists are welcomed, references should otherwise be kept to a minimum with the exception of reviews of literature.
3. Two copies of the manuscripts should be submitted along with a 3½" disk with the document saved as Microsoft word or ascii. They should be double spaced, with one-inch margins on each side. The *American Medical Association Manual of Style*, 9th ed. should be followed. The title page should include the author's name, degree, title, place of work, corresponding address, phone and FAX numbers, and email address. The manuscript should be sent to: *Orthopaedic Physical Therapy Practice*, ATTN: Managing Editor, 2920 East Avenue South, Suite 200, La Crosse, WI 54601-7202.
4. Black and white photographs to accompany the texts should be glossy 5x7. A photo release form must accompany any photographs where patients may be seen. Any tables that might add to the usefulness of the article are also welcome.

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