# ORTHOPAEDIC PHYSICAL THERAPY PRACTICE

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ORTHOPAEDIC SECTION
PRACTICE EDUCATION RESEARCH
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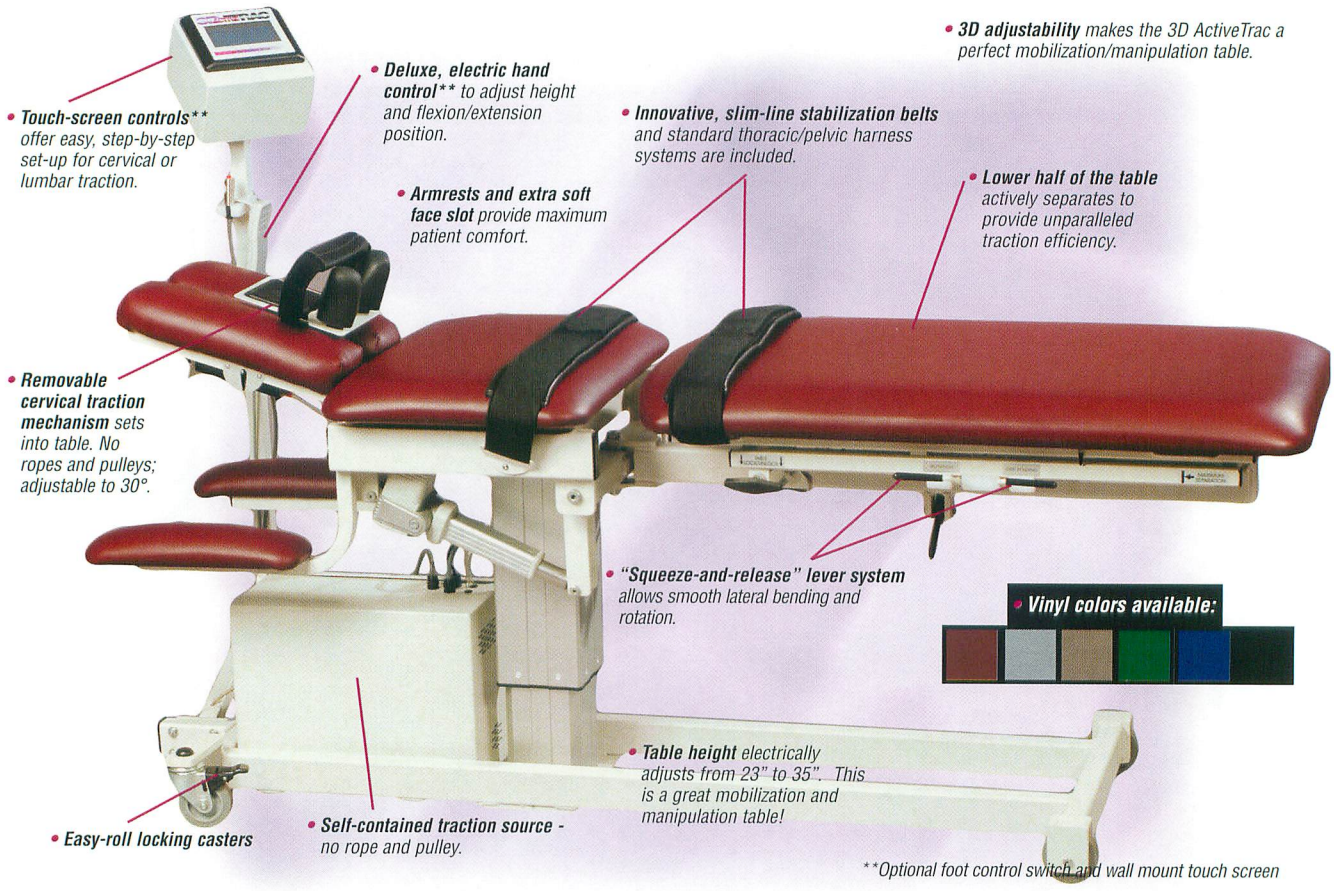

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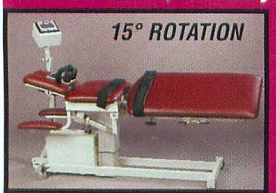




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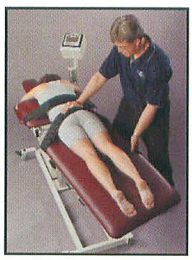

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# ORTHOPAEDIC PHYSICAL THERAPY PRACTICE

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**MISSION**

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

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

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# Editor's Message

*We want you. We want you. We want you as a new recruit!*

One of the highlights of each CSM is the Recognition Ceremony for newly certified clinical specialists. This year was no exception. One of our Section's own, Rick Ritter, gave an informative and very entertaining talk, addressing "What's Next?"—for these new specialists, and for the rest of us as well. As I sat in the crowd watching each new specialist walk down the aisle and be recognized, I felt a sense of pride in those individuals who rose to the challenge of the specialist process and succeeded. I was especially proud this year because 2 of my former students became ABPTS certified specialists—the first time a student I taught has reached this goal. I felt like a proud parent. Thanks Becky Hicks and Ken Finley for making me proud! For those of you who have never attended one of these ceremonies, you should make it a point to attend next time you are at CSM.

Speaking of students, have you talked to any students lately who are interested in physical therapy? I am not talking about students who are already admitted to physical therapy programs, but those college and high school students who are developing an interest in PT. Have you had an opportunity to speak to a group of students about physical therapy or attend a career day at a local school? Sometimes these opportunities present themselves while sitting in the bleachers waiting for your child to play ball or compete in a gymnastics or track and field meet. Sometimes, the chance comes when your children's friends want to know what their parents do for a living. You never know when you will have an opportunity to talk to a young person about becoming a physical therapist.

As a faculty member, I have lots of opportunity to talk with students who have not yet been admitted to a PT program. However, these chances seem to have decreased over the last few years. In fact, the number of students applying to physical therapy programs across the country is down. There are several potential reasons for this decline. One is that many programs were in transition at some point over the past 5 years, either moving from bachelor's to master's or master's to doctoral level education. That translated into more years in school for potential students, and increased cost of education. This could be one reason for decreased applicant pools. Another reason for the decrease might be what potential PT students are hearing in the clinics. One of the things we hear from some students is that clinicians tell them to reconsider their choice of PT as a career. In fact, some students have said that PTs and PTAs have actually told them not to enter the profession. We were quite surprised by this information. However, as we began to investigate further, we started putting things together.

Employment-related issues have a big impact on job satisfaction. Remember the Vector report that projected a surplus of PTs? Remember the fallout associated with the Balanced Budget Act (BBA) of 1997? That is when the $1500 cap on therapy services began and many companies began to cut back. For the first time in our history, there was unemployment in physical therapy. In many cases, PTs and PTAs didn't lose their jobs, but they were forced into mandatory reduction of hours. In the initial employment survey conducted by APTA in fall of 1998, a 1.2% unemployment rate was reported among physical therapists. According to APTA surveys since that time, unemployment among PTs peaked at 3.2% in fall 1999, while the peak unemployment rate for PTAs was 6.5% in fall 2000.[1] During that time, we complained about the seemingly ever-growing number of PT programs, and even passed a motion in the House of Delegates related to this concern. We were laid off—especially in home care and skilled nursing facilities—and we closed practices, home health agencies, and even some PT and PTA educational programs. We were not happy.

During that same time, high school and college students planning their careers saw physical therapy fall off the *top ten* list of professions. In addition, these same students who were learning more about PT by observing or volunteering in clinics and hospitals were told by PTs and PTAs to *pick another profession*. I suppose those students listened, as that advice is now catching up with us. Students who should have been applying to PT school now (and in the last couple of years) have not done so, partly because 3 or 4 years ago they were told to choose something else. Three and 4 years later, our pool of applicants for programs across the country continues to drop.

Initially, many of us were glad when the number of students entering the profession began to drop a little. Maybe we saw it as having one less new grad with whom to compete for a particular job, or as having fewer tests to grade. Because of the market in 1999 and 2000, we welcomed that initial drop. However, the number of applicants is still falling. Upon talking about this issue with other PT faculty across the country, I hear some common threads. Physical therapy programs are not filling classes because they don't have enough qualified applicants. Programs are having to offer more tutoring to students and are losing more students after they are admitted to the program because they can't make the grades. The PT programs are getting fewer of the *best and brightest* students, as they are selecting other professions. I am sure that there are many other possible reasons as to why our numbers are down, but the ones given are commonly heard.

So, you may ask, "What is your point? What does this have to do with orthopaedic physical therapy and me?" Well, the point is, each of us has to be an ambassador of our profession. We must encourage those interested in physical therapy to pursue it. Teach young people about what you do. Talk at your child's career day. If you don't have kids, do a presentation at a local high school or community group. We often talk about being ambassadors for our profession to legislators, but we also have to be ambassadors to potential therapists—those young, eager persons who want to learn more about what we do. We have to sell PT to politicians and third-party payers, AND to potential students of physical therapy. We cannot expect the best to come to us. We must go out and seek the best, actively recruiting them.

The good news is that the job market has opened up. APTA's latest employment survey in November 2001 reported a 1.1% unemployment rate for PTs and 3.9% for PTAs.[1] Just last week, I got 3 calls from recruiters telling me about job openings in my area. This year, we are actually hosting a job fair for our students—the first one in 2 or 3 years.

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# President's Message

I just recently got home from Boston. With over 5200 registrants, CSM was a great success this year. Paul Howard, our Education Chair, deserves our heartfelt thanks for all of his hard work, as does the entire Education Committee. Although being from St. Louis and going to Boston after the Super Bowl, I must say I was treated very well. The Patriots' win must have brought some new life to the city. Downtown construction appeared to be strong; the weather was great; people were buzzing along everywhere. Even the tunnel from the airport, although it seems like it is forever being worked on, appeared cleaner and had less traffic than I last remember.

At CSM the platform and poster presentations looked better than ever. New clinically challenging ideas were omnipresent with more therapists than I can remember crowding around the poster presenters. In addition, therapists appeared to be a mixture of curious young and wise veteran therapists who were actively engaged in enthusiastic debate and dialogue. Boston seemed vibrant and alive with activity. All of this does not happen magically. Many hours of hard work go into making this meeting a success. Besides Paul Howard, a special thank you goes to our outgoing Research Chair, Phil McClure, for all of his hard work. Moreover, the Special Interest Groups appeared to have rooms filled with therapists during their presentations. A very special thank you goes to Stefanie Snyder, Program Coordinator at the Orthopaedic Section office, who helps coordinate all of this work—thank you Stef for your many hours of service. Terri DeFlorian, our Executive Director, continues to keep our office running smooth, despite missing two employees (Tara Frederickson and Kathy Olson) who are on maternity leave (both moms are doing well). Thanks Terri and everyone else at the office.

The Orthopaedic Section finished its Board meeting in one day and the Orthopaedic Section Business Meeting went well (my first one as President). I am glad to have one under my belt.

The highlight was the Awards Ceremony later that night. The Orthopaedic Section recognized Ann Grove, who has finished her term as Treasurer; we welcomed Joe Godges as our new Treasurer. Gary Smith, who is finishing his first term, was re-elected for a second term as Director. Phil McClure was recognized as outgoing Research Chair, and we welcomed our new incoming Research Chair, Jay Irrgang. Mary Milidonis finished her final year of a 3-year term on the Nominating Committee. Bill O'Grady will take over as Nominating Committee Chair, and we welcomed Susan Michlovitz who was recently elected to the committee as nominating committee member. Finally, Jennifer Gamboa finished her term of office as President of the Performing Arts Special Interest Group, with Jeff Stenback being elected as the new PASIG President. I would like to thank each and every one of you for all the work you have done, or in advance for the work you will do. Volunteer organizations such as ours depend on caring people who donate their time and effort to try and make our profession better for all of us. Certainly, all of these people did just that. We appreciate your dedication.

The Awards Ceremony and Black Tie and Roses honored 4 different people for their outstanding achievements. First, Todd Davenport was named the Outstanding Orthopaedic Physical Therapy Student. Todd is from the University of Southern California. It was nice to hear all of the good things that were said about someone who is just starting their career in physical therapy; I was energized. Next, Kornelia Kulig was named the James A. Gould Outstanding Orthopaedic Physical Therapy Teacher. Kornelia teaches at the University of Southern California. Chris Powers, Kornelia's colleague, introduced her and described in detail all the reasons why she so deserved this important award. William Boissonnault, immediate past Orthopaedic Section President, introduced Nancy White, immediate past Vice President, as the 2002 Paris Distinguished Service Award recipient. Nancy gave a moving speech asking orthopaedic physical therapists not to forget the importance of funding research to improve our practice. Finally, Daniel Riddle was awarded the Steven J. Rose Award for the *best* orthopaedic physical therapy article written in 2001. Dan gave an inspiring (20 minute, thank you Dan) speech about his heroes in physical therapy—those therapists who taught, coaxed, and inspired Dan to become a better therapist through their actions and their words. Congratulations again to the 2002 Class of Award Winners.

At the Orthopaedic Section Board of Directors meeting a number of motions were adopted. First, we adopted a motion to examine the structure, current policies, procedures, and communication between the Special Interest Groups, education groups, and the Board. With Orthopaedic Section Board members, SIG Presidents, and Committee members scattered across the country, we realize the importance of communication among all of the different groups that make up the Section. This motion should improve our ability to work together as a team. The Board also adopted a motion to support an RC on interstate reciprocity to allow therapists to work with performing artists and athletes from state-to-state. We also will co-sponsor a motion with the APTA BOD regarding continuing education for individuals other than physical therapists and physical therapist assistants. You can read the drafts of these proposed motions in the Board Meeting minutes on pages 20-21. Finally, the Orthopaedic Section's Board agreed to donate 10 Home Study Courses to the Orthopaedic Specialty Council in an effort to provide more incentive to item writers in the development of exam test questions for the Orthopaedic specialty exam.

Finances have been tough this year. Ann Grove, in her final report to the membership, gave us better insight as to where we are currently (see financial graphs on pages 25 & 26). The recent downturn in the economy and the stock market coupled with a significant number of nonrecurring items have led to a decrease in our reserve funds. For example, two $50,000 grants for research to the Foundation; donation to Diversity 2000 for scholarships; money donated to the Pediatric Section from our Pediatric Home Study Course; and JOSPT transition expenses were all expensive nonrecurring items. In addition, our incoming revenues have slowed down partly related to the transition in editorship of our best nondues generating revenue source, our Home Study Courses. The Board realizes that most of these items are nonrecurring and thus will only temporarily slow us down. We are optimistic that the economy will get better and our Home Study Courses will continue to do well. To help us through these tough times, the Finance Committee was indeed very

*(continued on page 12)*

# The Therapeutic Use of Yoga

**Marie Janisse, PT**

## INTRODUCTION

Physical therapists are aware of the relationship between stress and physical pain. Stress affects every cell, tissue, and organ. It lessens our joy of living and creates a less focused, less serviceable mind. By including certain techniques from the Yogic tradition in our practice of physical therapy, we improve the outcomes of our treatment while reducing stress and creating awareness of patterns that sabotage treatment.

This paper will look at the mechanisms involved in the therapeutic use of Yoga in the treatment of pain and stress-related disorders. It will describe aspects of Yoga that improve the outcomes of physical therapy treatment and are easily incorporated into a rehabilitation setting. It will include: (1) a discussion of Yoga and its current use, (2) the components of a Yoga therapy session, and (3) the application of the tools and philosophy of Yoga by the physical therapist.

## THE "S" IN SOAP NOTES

A Yoga session begins by bringing awareness to the breath and bodily sensations. It begins by asking the person to focus more deeply on sensations in the body. Metaphorically, the therapist asks the question, "Have you noticed?" It seems appropriate to begin an article on Yoga in rehabilitation by asking the same question: "Have you noticed?" . . .

- Have you noticed how a client reinjured his back because he lifted a 60-pound bale of hay when his lifting was restricted to 25 pounds? "No one was there to help."
- Have you noticed how a client's hip pain returned after planting 100 bulbs? "The pain increased with each bulb I planted, but the gardener didn't show up and I had to get them in."
- Have you noticed how a client can be so driven to (a) compete in group sky diving that he could cause a partial rotator cuff tear to become a complete tear? or (b) go backpacking with a bulging disc because the trip was planned 2 months prior? "They were counting on me."
- Have you ever witnessed the compulsion to do a headstand in a Yoga practitioner even when told that it would further damage the spine?

I call these examples the "I-have-to-do-it syndrome." Physical therapists deal with this in a variety of ways. One of my teachers used to say, "This problem is supra-tentorial," or "Your problem exceeds the limits of my expertise." The Yoga therapist would say "If a client continues to do a headstand after being told it will further damage his spine, then we are not treating the body, we are treating the mind." In our "SOAP" notes, this is "S."

By including certain techniques from the Yogic tradition in our practice of physical therapy, we improve the outcomes of our treatment while reducing stress and creating awareness of patterns that sabotage treatment.

The mind can sabotage even the most perfectly formulated treatment plan. Patanjali's Yoga Sutra, the definitive guide to Yoga, defines Yoga as the "ability to direct the mind without distraction or interruption." Desikachar, the lineage holder of the Viniyoga teachings says, "Specifically, the Patanjali Yoga Sutra concerns the attainment of a stable mind and healthy body so that personal goals may be achieved. Such attainment is independent of cultural background and religious inclination."[1]

## A RISING INTEREST IN INTEGRATIVE APPROACHES

The increased workload and lower reimbursement rates for physical therapy in the past 10 years coincide with problematic ethical situations. Both doctors and physical therapists are experiencing progressively less control over diagnostic procedures and treatment plans. Concurrent with these challenges to the practice of medicine and physical therapy, there is a growing interest in complementary and alternative medicine (CAM). Speaking in Santa Barbara on 1/22/02, Larry Dossey, MD presented the following statistics: The use of CAM from 1990 to 1997 increased from 420 million visits to 629 million visits and from $14 billion to $21 billion, over half of which was out-of-pocket. Editor of *Alternative Therapies*, Dossey states that people are choosing alternative medicine in addition to traditional medicine, not instead of it. He suggests that the interest lies in the fact that CAM resonates more closely with their worldview. This is concurrent with a rising interest in spirituality in medicine—over 80 medical schools are now offering as part of their curriculum, courses which study the effects of intercessory prayer and demonstrate the benefits of spirituality in adding longevity to a person's life and decreasing the incidence of disease.

Nowhere is this trend more obvious than in the rising interest in Yoga. In a feature article, on April 23, 2001, *Time* magazine reported that the number of people including Yoga in their fitness regime has doubled in the last 5 years. Seventy-five percent of all US health clubs offer Yoga. Given the competitive nature of many of the practitioners and the extreme postures that are often used, it is not surprising that there has been an increase in the number of Yoga-induced injuries. Many of these injuries have an onset that is so slow that it cannot be directly linked to Yoga. Gregory Johnson, PT, FFCFMT, President of The Institute of Physical Art Inc., reports, "Long-term Yoga teachers have a higher than normal rate of disc degeneration, particularly those who have emphasized deep spinal stretches."

We can support the needs of this population of Yoga practitioners. This is especially important since a large number of people receiving Yoga therapy for stress-related disorders in medical settings also suffer from musculoskeletal pain syndromes. Physical therapists are movement experts, whereas the training of Yoga teachers and Yoga therapists does not include pathokinesiology or kinematics. By blending the strengths of Yoga with the knowledge of physical therapy, we open our profession to learning new treatment methods and gain valuable insights from an ancient wisdom tradition.

## YOGA: SYNCHRONIZING BODY AND MIND

Contrary to popular belief, Yoga does not require excessive length of muscles or excessive spinal range of motion. The beauty of Yoga is that it can be done by

anyone who can breathe and think a thought. The poses that are commonly associated with Yoga are only one of the tools of Yoga. Other tools include breathing techniques known as pranayama, and meditation or relaxation, which may include visualization.

Yoga is different at different stages of life. In the aging population, or with any debilitating condition, Yoga focuses primarily on pranayama and meditation, with slow mindful movement determined by a person's physical condition.

Today, there are many schools in the U.S. teaching different styles of Yoga. While they differ in outward form, a common thread is the intent to enhance self-awareness. On the level of thought/emotion (known as *mind* in eastern philosophy), self-awareness centers on issues of personal mastery and relationship to others. On the physical level, the westerner appreciates increased strength, flexibility, stamina, and balance. From the perspective of Yoga, these physical benefits are merely by-products of a bio-energetic system powered by prana, the life force (*chi* in Chinese medicine). Yoga values the increase in overall vitality and organ strength, and most importantly, the ability to direct the mind and the body. While no public figure in the western world has accomplished the highest of the yogic feats, many western students of Yoga have described an experience of 'inner peace.' Yoga is a practice that is well suited to address the rise in stress-related disorders.

There are numerous Yoga therapy programs established in hospitals and clinics where stress is recognized as a factor in creating illness. Herbert Benson, MD, who coined the term *relaxation response*, is the President of the Mind/Body Medical Institute at Beth Israel Deaconess Medical Center. Yoga therapy is used at this facility as part of a comprehensive program to treat cancer, heart disease, pain, anxiety, infertility, chronic fatigue, headache, gastrointestinal disorders, and autoimmune disease. The Hospital for Joint Diseases in New York City has an 8-week resident program for chronic pain in which a physical therapist teaches Yoga in a class setting. While there are no figures showing the number of clinic-based Yoga programs in the U.S., in my hometown of 200,000 people, 2 of 3 hospitals offer Yoga for employee wellness. Two other programs are offered privately through the Multiple Sclerosis Society and the American Cancer Society. In addition, there are 2 physical therapists and 6 alternative medical professionals who use Yoga in their private practice.

The tools of Yoga are congruent with the latest findings in psychoneuroimmunology,[2] numerous studies on meditation, and the work of Jacobsen in the 40s on progressive neuromuscular relaxation. The Yoga Research and Education Center offers a bibliography of research documenting the effects of Yoga (including meditation) on all stress-related disorders.[3] While not within our academic training, the tools of Yoga fall within the scope of physical therapy practice. As one of my professors used to say regarding the cycling of physical therapy practices: "What was old is new again." From a 5000-year-old Vedic practice, to the neuromuscular relaxation techniques of the 1940s, to the current use of Yoga, we appreciate the value of enhanced awareness through a technology of silence and mindful movement.

The technology of India has been enhanced by each culture that it has entered. I suspect that its merging with western science will create a superior hybrid. Physical therapists are part of this process of hybridization, as exemplified in the following developments:

- Matt Taylor, MPT, RYT has presented numerous articles related to the use of Yoga therapy in rehabilitation. An overview of a Yoga program for clients following a total hip replacement was published in *Orthopaedic Physical Therapy Practice*.[4]
- My article published in the *International Journal of Yoga Therapy* presented a classification system to select asanas that would restore precision to joint movement and prevent repetitive stress.[5]

The number of physical therapists using Yoga in their practice is growing. How can we, as physical therapists, optimize the value of this ancient technology in our practice?

## THE TOOLS OF YOGA

The goal of the Yogic tools as currently used is to bring each individual into optimal health and peak performance. The Yogic perspective of health is multidimensional. We understand that life occurs in layers. The Vedic seers grouped these layers into 3 broad categories:

- The physical body, consisting not only of the material body, but also the bio-energetic field (prana) that infuses it with life force;
- The subtle body, consisting of the *lower* mind, (stimulus-response mind), and the *higher* mind (seat of discrimination and wisdom);
- The causal body or spirit, which causes all the above, denser bodies to come into being.[6]

From the bodily systems to organs, tissues, cells and beyond, we are invited to a depth that finally exhausts our technological skills. In Yoga the layers go where technology cannot.

Disease is considered a separation from our true nature. It begins in the most subtle body and then moves to the physical manifestation of illness. Illness can be considered a *reset* button that prompts us to take the responsibility to look deeper into thoughts, emotions, and beliefs that are causative. *No pain, no gain* is one example of a popular myth, a cultural belief, that breeds recurrence of pain and disease through excess and through separation of body and mind. True healing occurs at all levels only when causative factors are addressed. In my opinion, this is holistic healing. It can occur in the physical therapy department with the tools of asanas, Yogic breathing (pranayama), and meditation (including prayer, guided self-inquiry, and relaxation).

The influence of stress in disease has been largely unrecognized until recently. It is only with the advent of psychoneuroimmunology that we have begun to take notice. Understanding the intimate chemical connections between the nervous system, the endocrine system, and the immune system fosters respect for the dangers of stress. The same mind/body connection that causes a person to blush in a moment of embarrassment also can send cortisol and adrenaline in response to thoughts of fear.

Cortisol and adrenaline are helpful in life threatening situations. The body responds to the needs of the moment and then returns to its normal mode of operating. However, in our society, the perception of threat goes beyond the imminent threat to our survival. Fears can be born of fatigue and loneliness. Anger and frustration can arise from a pressured life style. It requires progressively less stimulus for our body to respond by sending extra cortisol into the body. When low levels of stress chemicals remain in our blood stream over time, we experience chronic stress as a conditioned response to our life style.

The success of Yoga therapy in treating pain and stress-related disorders is explained by Joseph Le Page in the Integrative Yoga Therapy Manual: "The practice of asana, pranayama, and meditation begins to quiet noise in the mind and allows us to get past the filters in the mind to an experience of inner peace. Done regularly, the conditioned responses weaken and we begin to witness them for what they are—just habits of percep-

tion. We begin to notice that peace and contentment are not conditioned by external experience. We begin to have more options in how we respond to life and how we create our reality."[6]

Yoga provides a multifaceted approach to treating the stress component of pain. Research in this field is well underway, though complicated by individual variations in the perception of stress and the many ways that it manifests in the mind and physiology. A bibliography of research on Yoga in the treatment of chronic pain can be obtained from the Yoga Research and Education Center.[7]

The use of alternative treatments is slow to be accepted by some. Yet leaders in our field of physical therapy recognize the need. In his Mary MacMillan lecture, at the Annual Conference and Exposition 2001, Jules Rothstein PT, PhD, FAPTA asked the question, "How long can we tolerate the intellectual dishonesty of those who argue that to embrace new methods or to use what are called 'alternative treatments' means that we must abandon scientific inquiry and clinical trials? New ideas and radical notions become accepted quickly when they are demonstrated to have clinical benefits, not when we whine about the impossibility of research."

### Asanas

There is a common tendency in the western world to reduce Yoga to asanas, and to further reduce asanas to stretching. Combined with a *more is better* mind set, this can be damaging. Asanas are merely 1 of the 8 components of Hatha Yoga as described by Patanjali's Yoga Sutras. Hatha Yoga is only one of numerous forms of Yoga. Asanas can not only stretch, but also strengthen and stabilize our physical structure and benefit the physiology and mind as well.[7]

The essential qualities of asanas are from the Sanskrit words—*sthira,* steady alertness; and *Sukha*, light and comfortable.[1] When Yoga is applied therapeutically, the poses are adapted to the individual as directed by the physical therapy evaluation. Incorrect use of asanas to create excessive spinal flexibility or muscle length can cause injury, and prematurely age our movement system. Ahimsa (the philosophy of nonviolence) is in agreement with the Hippocratic oath: "At least, do no harm."

Our physical needs are different now than they were in the early practice of Yoga. Modern careers and recreational activities create physical and mental demands that were not part of the life of the ancient yogic saints. In addition, we have evolved in our understanding of our movement system. We understand the importance of maintaining optimal muscle length.[8] We know that excessive muscle length alters the control a muscle has over the segments that it influences, leading to repetitive stress and eventually pain.[9] As Yoga incorporates this knowledge, it evolves. By respecting our body's biomechanical needs, we increase the longevity of our movement system and the chances for a long and pain-free life. For an introduction to the indications and contraindications in selecting Yoga asanas using an application of Movement System Balancing,[9] the reader is referred to my article, *"Correcting Movement Imbalances with Yoga Therapy."*[5]

Historically, there have been thousands of asanas documented, along with their modifications. Thus, all therapeutic movement performed with full attention and coordinated with inhalation and exhalation can be considered a part of Yoga therapy. Depending on the degree of pathology, the poses are performed either statically or dynamically in what is called Vinyasa, a series of flowing movements. When asanas are linked to the breath, they affect not only the physical body but also the mind. It is through the breath that we can truly link the mind to the body.[10]

## YOGIC BREATHING

### Pranayama

There are many breathing techniques used in Yoga, each with its specific effect on the physiology and the mind. Some forms of breathing are used to energize the body. Some are used in strengthening poses to teach the body to respond to stressors without weakening the immune system. The diaphragmatic breath stimulates the parasympathetic nervous system. It reverses the cycle of stress and rapid shallow breathing that is characteristic of the stress response. The Ujjayi breath improves balance and endurance in more challenging asanas. Most importantly, the combination of asanas and pranayama has a balancing effect on the mind. Together, they remove the distractions and tensions in the body and the mind as a preparation for meditation.

### Relaxation/Meditation

In speaking of Yoga, one Tibetan Buddhist nun told me, "When you calm the body, you calm the mind. Then you clear a space to look at fear, attachments, and anger." Meditation is a time to go within; for some, it is a time of self-inquiry. Some clients may choose to use this time for silent prayer or for an already established meditation practice.

Instruction in meditation can take many forms. A Tibetan Buddhist form of mindfulness meditation is taught by Allan Wallace, a former faculty member in the Department of Religious Studies at the University of Santa Barbara, CA. Author of many books on Tibetan Buddhism, Wallace speaks of the importance of developing *attentional stability*. The meditations can be used while clients are on modalities in the department to develop the ability to focus the mind. The first mindfulness meditation centers on sensations in the body. Progressively more challenging is the ability to stay focused on the breath, on the thoughts that come and go, and finally on the mind itself. These initially require verbal guidance and can be as short as 5 minutes.

Another form of meditation repeats a sound (mantra). Herbert Benson, MD uses this form at the Beth Israel Deaconess Medical Center connected to Harvard University. Mantra, energized sound or sacred word, is the basis of all religious traditions, scriptures, and prayers. In one form or another, it is the key religious practice of humanity.[11]

Initially, when a person quiets the mind, the relaxation response will cause drowsiness and the person may fall asleep. It is estimated that 80% of our population is sleep deprived. For this reason, some advise taking one-half hour of rest before beginning asanas so that meditation can go beyond drowsiness into a state of inner wakefulness. In this state, the heart rate, respiration rate, and blood pressure decrease, while the mind stays alert. To a degree this may be experienced in single-pointed activities such as gardening, giving a massage, most forms of art, and during the practice of asanas and other forms of movement meditation. The more this state is cultured in the nervous system with a sitting meditation practice, the more it flows into our activities. Advanced Yogic masters can experience all activity from this level.

Meditation is an important tool for healing the mind and the body. Recent studies by both Dean Ornish and the Transcendental Meditation movement suggest that stress reduction by itself can reduce atherosclerosis without changes in diet and exercise. The latter study was published in the March 2000 issue of the American Heart Association's journal, *Stroke*. Director of the Preventive Cardiology Center at Cedars-Sinai Med-ical Center in Los Angeles, Dr. Noel Bairey-Merz says, "This is one of the few proven stress management techniques that has been tested with our best science. I would concur that it appears to have an effect on blood pressure and carotid artery thickness, and it has no adverse effects."

## THE THERAPEUTIC USE OF YOGA IN A REHABILITATION SETTING

### Dedication

In his speech on spirituality in medicine in Santa Barbara, CA on 1/22/02, Larry Dossey, MD said: "Before he begins to operate, one surgeon raises his hands and says, 'God, these are your hands. Please don't embarrass yourself'." Tibetan Buddhists ask that all their thoughts, words, and actions be for the purpose of eliminating suffering and the causes of suffering from all beings. It is valuable to take a few moments at the beginning of our workday to dedicate the merits of our actions in keeping with our spiritual beliefs or our purpose in life. This forms part of a Yoga practitioner's personal practice of Yoga. By deepening one's own practice, the work with others improves.

### The Physical Therapy Evaluation

There are many meanings of the word Yoga. One meaning is *to attain what was previously unattainable.*[1] In order to do that we must evaluate and accept where we are. Using the integrative approach of Yoga therapy, the evaluation includes the *layers* of both the body and the mind as described above.

The evaluation begins in the waiting room with a form that asks about the client's appetite, quality of sleep, level of energy, fulfillment in career and relationships, etc. No advice is given regarding the answers. Often the client can see the connection between these questions about their quality of life and the pain they are experiencing. The questions serve the client as a tool for self-reflection and for establishing personal goals. The client's answers may reveal the need for an outside referral.

### Subjective

As the patient describes the behavior of the pain and how it occurred, it may be possible to hear more than just the mechanism of injury. In many instances, beliefs, attitudes, impulsive behaviors, or compulsive tendencies complicate both the cause of injury and the treatment. From the perspective of therapeutic Yoga, evaluation is a process of increasing awareness.

Therapeutic Yoga strives to deepen a person's awareness of his or her body and his or her sensations so that the referral process is internal. The client becomes self-referring in establishing limits. Those who have closed off the perception of pain in order to *get on with life* may find it difficult to know their tolerance levels. It may be useful for the client to keep a journal of the positions and activities that increase pain. The tolerance levels can then be established, and the client can learn to pace activities and budget his or her energy and time. I ask for a rating on a scale of 0 to 10 during any discussion of pain. Whether the patient is in denial or is a symptom magnifier, this serves the purpose of objectifying a very subjective and often frightening experience.

### Objective

Evaluations differ with each therapist. A large part of my evaluation protocol consists of movement and postural tests taken from Movement System Balancing. *Diagnosis and Treatment of Movement Impairment Syndromes* by Shirley Sahrmann, PT, PhD, FAPTA contains the neurological principles underlying this approach and includes the complete evaluation and treatment protocol. The movement diagnosis obtained directs the treatment. The correction of movement and postural faults begins with the evaluation, along with the instructions for altering ADLs. This testing increases awareness of movement and postural faults and the treatment protocol lends itself well to establishing a Yoga therapy program from the first day. Using the approach of Movement System Balancing, the client can immediately feel the change in pain level when the faulty movement pattern is corrected. This creates an eagerness to perform the home program.

Evaluation of the client's breathing pattern is important in relieving pain. Often the breathing includes accessory muscles which, if not corrected, will perpetuate neck or headache pain. The body may respond to pain by creating a shallow breathing pattern. Over time, a person with pain and/or chronic tension becomes a shallow breather. The quality of the breath both influences and is influenced by the autonomic nervous system. To break a cycle of stress, muscle spasm, and pain, it is important to evaluate and correct the breathing pattern.

In my early practice of physical therapy at Rancho Los Amigos in Downey, CA, there was a 4-point system used to describe the relative use of the diaphragm, intercostal, and neck muscles. In Yoga therapy the evaluation of the breath is more comprehensive and covers 4 to 5 additional parameters. Breathing techniques vary in their ability to energize or relax the body, and to create heat or to cool. They have a stabilizing effect on the mind. Choices are made based on the evaluation of the breathing pattern and the pathology.

In my clinical practice, I have found that there is value in establishing a partnership where commitments are made on both sides. I commit to using my highest skills as a therapist who truly cares about the client's well being. In return, I request that the client commit to 2, 20-minute sessions a day to perform a home program and that they follow all recommendations for pacing and modifying activities and positions unless they notify me. I explain that the key to recovery is a commitment to doing the work and a willingness to observe one's self.

## PHYSICAL THERAPY TREATMENT USING THE TOOLS OF YOGA

We may never see CPT code 97101, *Building Awareness*, but we can build it into every part of our practice. The beginning of every movement session begins with 2 to 5 minutes of breath and body awareness, verbally guiding the client through a scan of the body. The client's attention is drawn to aspects of the breath and the body in a sequential manner: for example, the weight of the foot pressing onto the treatment table and later, noticing the space behind the low back. "What you feel, you can heal" is as true for the body as it is for the emotions.

Each physical therapist has a unique set of treatment skills. Yet each method requires breathing and moving and can benefit from the lowered sympathetic arousal and greater mental focus that occurs when the two are consciously combined. Following is a sample of a sequence I use with clients:

| | |
|---|---|
| Breath awareness/ Sensory awareness | 5-10 min. |
| Asanas | 15-20 min. |
| Pranayama | 5 min. |
| Meditation/relaxation | 5-10 min. |
| Home program review | 5-10 min. |
| | Total: 35-55 min. |

When time is limited, even a 20 minute program of asanas coordinated with the breath (15 minutes) and followed by meditation/relaxation (5 minutes), provides an experience that can be carried through the day to the client's practice at home. I find it useful to keep a tape recorder handy to record those portions of the treatment that are to be repeated at home. The audiocassette is a simple way to note a number of details specific to that client. It is also an easy way to tape a guided relaxation sequence to follow asanas for home use (usually a total of 20 minutes).

By incorporating Yoga therapy into the treatment principles of Movement System Balancing, I find that precise work can be done very quickly: (1) In the neuromuscular re-education of a dormant

muscle, for example the lower trapezius, the slow mindful movements, performed submaximally, minimize the over-recruitment of dominant muscles and maximize participation of the dormant muscle. (2) The slowness of the movements performed with full attention and paced with the breath minimizes the interference of subcortical programming. It enhances kinesthetic awareness. (3) The slow pace induces muscle relaxation where muscle spasm or pain exists. (4) Coordinating the movements with the breath ensures that the person does not hold their breath or breathe so superficially that they cause or increase a stress response. In addition, mental focus improves with the correct breathing technique. (5) After re-education, strengthening occurs with the benefits of a relaxed nervous system, optimal cellular respiration, a focused mind, and enhanced sensory awareness. (6) Once the client can perform all movement tests with a stable pelvis, this skill can be integrated at a deeper level with progressively more complex asanas that challenge their kinesthetic awareness.

### Additional Notes

All asanas can be taught with a neutral spine—and must be if movement tests demonstrate a pattern of pelvic instability connected with pain. Asanas frequently occur at the end range of motion where opposing muscles can be stretched and strengthened simultaneously while reinforcing the lessons of spinal stability. The sequencing of asanas is a subject that goes beyond the scope of this article.

I received my first instruction in asana and meditation in 1973, shortly after I began work as a pediatric physical therapist in a school for developmentally disabled children. As I was learning the sequence of 7 to 8 asanas, I was surprised to find a strong correlation with the sensory integration routine I had been using with the children. In both the asanas and in physical therapy, we started with sensory stimulation — rubbing and squeezing the body from head to toe. Then, with knees to chest, we rolled from side to side. This was much tamer than the obstacle courses I had created for the children, rolling up and down inclines and under tables. The next Yoga poses were the same as the reflex-inhibiting postures that I had done with the children both in prone and then in supine positions. The similarities continued with a kneeling pose, an inversion pose, a gentle twist, and finally the relaxation pose (savasana). In the Yoga class, this was the preparation for pranayama and meditation. At the school, meditation took the form of a centering activity—playing with sand, clay, or water.

Whether we work with neurologically involved clients or orthopaedic clients, stimulating the tactile, proprioceptive, and vestibular centers benefits the nervous system in many ways including emotional well-being.[12] Props can be used in Yoga poses to support the body in various spatial orientations. Whatever program of exercise we create for our clients, there is value in providing contrast in orientation to space and contrast in alternating the use of opposing muscle groups (counterpose).

Once the mind has settled with asanas, it is helpful to spend a few minutes using one of the Yogic breathing techniques to prepare for relaxation or meditation. For those who have more time and wish to experience even greater benefits from meditation, I recommend a study of Yoga Nidra or Tong Len. Yoga Nidra combines relaxation, affirmation, and visualization for work on all levels of being. Tong Len is a spiritual practice of Tibetan Buddhists developed to increase compassion and loving kindness towards all.

The time given to prayer, meditation, or relaxation after a treatment maximizes the effect of the treatment. Dating as far back as the 1970s, I found that clients in the clinic could achieve a relaxation response within 3 to 5 minutes by guiding their attention to each body part. When personal instruction was not possible, we used guided relaxation or visualization on audiocassette tape. If time is limited, the use of prayer, meditation, or listening to a relaxation tape can be done privately after a treatment by providing a client with a quiet space where the time in silence is undisturbed.

As an example of a client's response to relaxation, the following is the experience of a person with chronic fatigue immune dysfunction and fibromyalgia who had a history of overworking. She reports, "I used to be so uncomfortable with inactivity that I worked full time when I was in graduate school and then took a second job just so I wouldn't sit still. The relaxation tapes[13] reversed that. I felt as if I didn't want to do anything else—like I couldn't move my body and that was good!" The benefits of relaxation combined with the work of the asanas performed with focused breathing, caused this person to drop 2 sizes in her clothing. She had gained muscle mass so that the decrease in body weight was only 10 pounds.

In a second example of the wholistic benefits of this approach, a technology executive had been severely injured in a car accident. He reported, "I've had the first 4 pain-free days in 20 years. A calmness has come over my body that I haven't felt in a long time."

It is this response of the nervous system that, with regular practice, flows into the activities of our life. It makes us more aware of how we treat ourselves so that we do not cause further injury. It is the basis for true healing.

### CONCLUSION

In summary, it can be said that:

1. The slow repetitive nature of a movement performed with full attention and paced by the breath has numerous benefits:
   a) the process of motor relearning occurs more easily;
   b) neuromuscular relaxation is enhanced;
   c) sympathetic dominance is decreased with correct breathing. This increases blood flow to the muscle, normalizes muscle tone and optimizes cellular repair; and
   d) mental focus is improved.
2. There is improved ability to re-educate muscles and stabilize segments through increased kinesthetic and sensory awareness.
3. New patterns of movement and posture are more readily integrated into daily activities.
4. Breathing patterns are corrected to provide a foundation for improved health.
5. Recovery time is shorter with reduced recurrence of pain through greater awareness of behavior that causes pain (physical and cognitive).
6. Stimulus to the tactile, vestibular, and proprioceptive centers benefits the entire nervous system and affects emotional well being.
7. By conditioning the nervous system to a state of restful alertness with a regular home program, the effects of meditation become cumulative and affect our moment-to-moment activities and relationships.
8. With fewer "I-have-to-do-it" moments, there are greater options for directing one's life.
9. Performed regularly, a therapeutic program of Yoga can stabilize the body and mind. Performance is optimized and quality of life is improved.

Through the ages and in many cultures, it has been said that true healing must begin within. It begins when we realign our activities, speech, and thoughts with our highest values and when we re-establish our priorities. The mind plays an important role in this. By making small changes in the way we

evaluate and treat clients, we can effect changes in the mind that empower a person more fully to express his or her potential. Through regular Yoga practice, it is possible to add quality to our own life and then to transfer this experience to our clients by using an integrative approach to healing.

This article is excerpted with permission from Marie Janisse's forthcoming book, *The Therapeutic Use of Yoga in Rehabilitation.*


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## Editor's Message

*(continued from page 5)*

Are the *good old days* coming back? Well, we can never really go back, but I think the market is finally leveling out. Jobs are out there—and not just any job, but one you want. So, encourage interested persons to find out more about physical therapy. Invite someone who is trying to decide about his or her career choice to observe in your clinic. Give them the web address for the APTA and Orthopaedic Section so they can find out more about "the science of healing, the art of caring." Above all, don't discourage them from entering the profession. Please take each opportunity you have to educate others about physical therapy, especially those who might be interested in joining us.

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

## President's Message

*(continued from page 6)*

careful when budgeting this year.

At the Orthopaedic Section's Business Meeting, two important motions were adopted. One was to form a task force to look into strategic planning with the goal of improving nondues revenue production, thus reducing our burden of debt. The second motion moved that a task force be formed to explore merging the Sports and Hand Therapy Sections with the Orthopaedic Section. Interestingly, we discussed this topic at the Sections Presidents Meeting too. What are the pros and cons of consolidation? Eliminating duplication of services, saving money by centralizing services, and concentrating efforts on areas of mutual concern are obvious pros. The cons of consolidation include the possible loss of services, bigger may lead to less personal service, and with a larger Section there is always the possibility of losing focus on an important individual or specific problem. While consolidation may be good for business, is it right for us? What is your opinion? I invite all Section members to respond and express your opinion of consolidation by going to our website at *orthopt.org* and enter your opinion on the Section's Bulletin Board. I would like to hear the positives and negatives of consolidation from the membership. Discussion and debate are always healthy—I am sure the task force would like your, our membership's, opinion on this issue.

Orthopaedic physical therapy is in the midst of a renaissance. The introduction of the seminal *Guide to Physical Therapist Practice*; the important role the Orthopaedic Section continues to play in funding the Clinical Research Network; the number 1 rating of JOSPT in rehabilitation (thank you again Rick DiFabio); the continued growth of our SIGs and educational groups; the increase in quantity and quality of both poster and platform presentations; and finally, despite difficult times, the growth in membership in the Orthopaedic Section all point to continued growth and success. As physical therapists we all know the very important role we play in improving the health care of our patients. We must show those who know little or nothing about us the skill of our hands, the intelligence of our thoughts, and the caring of our hearts. Moreover, together as a united organization, with conviction and concern, we can bring about lasting change that will make physical therapy better for all. Let us all strive to do just that.

*Orthopaedically yours,*
*Michael T. Cibulka, PT, MHS, OCS*
*President*

# Measuring Head Posture via the Craniovertebral Angle

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

**Timothy S. Hilliard, PhD**

## INTRODUCTION

Head posture (HP) is often assessed in the physical therapy setting, particularly during screenings for any upper quadrant dysfunction.[1-6] There are many instruments and procedures a physical therapist can employ to obtain measurements when assessing HP.[1,2,7-12] However, these instruments and procedures are not necessarily simple or standardized for measuring HP in the clinical setting. One method of measuring HP is via the craniovertebral (CV) angle.[13]

Methods for assessment of head posture include, but are not limited to, the following: the plumb line,[14] the Rocabado Posture Gauge,[12] the Cervical Range of Motion (CROM) instrument,[4] the flexible ruler,[14] photographic imaging including digital still photography, radiographic measurements,[11,16-18] the use of a computer assisted slide digitizing system called the Postural Analysis Digitizing System (PADS),[1] and a multifaceted approach by Harrison et al.[2] While each method has potential benefits, they all have limitations, and for some (eg, the PADS), the clinical applicability is questionable.

The plumb line is simple, but has many limitations. First, the method used to determine the degree of forward head posture is subjective. Therapists rate the severity of the anterior positioning of the head as minimal, moderate, or maximal without objective, numeric values. Second, discrepancies can be caused by the low percentage of reproducibility in viewing angulation of the examiner in relation to the patient, and/or the patient's standing posture in comparison to the plumb line.[13]

The Rocabado posture gauge has been shown to have high intra-rater reliability, but inter-rater reliability has not been tested.[12] Furthermore, the Rocabado posture gauge is unable to measure the craniovertebral angle, requiring yet another instrument to obtain this measurement of posture. The CROM instrument, which has been adapted with an extension arm for HP measurement, is cumbersome and its precision is ≥ 0.5cm.[4]

While the flexible ruler is a potentially useful tool in assessing cervical curvature in the sagittal plane, Rheault et al,[15] suggest the device is more difficult to apply to patients with cervical pain, disease, or pathology. Since forward HP is an abnormality believed to lead potentially to dysfunctional changes in the cervical spine, this may not be optimal for clinical use.

Problems associated with photographic imaging also are related to the time expenditure required for accurate assessment. Alignment of the camera and positioning of the patient are crucial variables if one is to obtain accurate objective measurements. In addition, this method does not necessarily permit for immediate results, which may be optimal in the clinic. One must also consider the cost factor. Radiographic imaging, which is effective and less frequently used for this purpose, is expensive and also exposes the patient to radiation.

The PADS is considered reliable and is easily used.[1] The major drawback, however, is that the system requires a chair with an 8 inch rod installed in the back, a 6 x 3 foot Plexiglas piece mounted on a wood frame, a camera mounted on a tripod, a slide projector, a computer, and a pressure-sensitive digitizing pad.

The approach by Harrsion et al[2] obtains measurements of head translation, shoulder translation, head-shoulder difference, cranial rotation angle, and neck inclination angle utilizing a wall, plumb line, metric-based carpenter's trisquare with a level attached to the horizontal arm, and a goniometer with a line level attached to the horizontal arm. While the methods used by Harrison et al[2] demonstrated high inter-rater reliability, the numerous steps are time consuming and this can be a problem in the clinical setting.

Forward HP [described in the literature as increased flexion of the lower cervical spine (C3-7) and increased extension of the upper cervical spine (C1-2), which places the head anterior to the body's center of gravity[1,3,7,11,12]] has been linked to numerous painful musculoskeletal dysfunctions.[7-8] These dysfunctions can be attributed to the imbalances of length and strength between the musculature and associated connective tissues of the cervical spine.[1-3] When the head is carried anterior to the body's center of gravity, the cervical joints are placed in a potentially stressed position.[2] The maintenance of an abnormal forward HP causes further imbalances and sets a detrimental cycle in process.[1-3,8] Dysfunctions that manifest themselves from the stresses placed on the joints and muscles of the cervical spine include, but are not limited to muscle spasm and pain,[1-3] early degenerative and spondylotic changes,[1-3] headaches,[1-3,12] temporomandibular disorders,[9] thoracic outlet syndrome,[3,8] and dorsal scapular nerve entrapment.[3] "Assessment of posture is an important component of the evaluation and effects the design of the treatment regime."[1] Forward HP can be associated with any of the above mentioned dysfunctions. It is important that the instrument and method chosen to assess HP in the clinic is reliable, objective, easy to use, and produces immediate results when assessing a patient's condition and progress.

One of the authors, Mary Ann Wilmarth, developed an instrument, the Head Posture Spinal Curvature Instrument (HPSCI), to measure both head posture and cervical curvature. This instrument was designed to eliminate the cumbersome use of multiple instruments in the clinical setting and to allow a more efficient assessment of postural abnormalities with immediate feedback for both the patient and the therapist. One objective of using the HPSCI is to obtain measurements of the CV angle as described by Watson and Trott,[11] Braun,[1] Lee et al,[9] Harrison et al,[2] and Hackney et al.[16] In addition, horizontal and vertical measurements taken with the HPSCI provide the information necessary to define spinal curvature. Studies are currently ongoing with regards to the spinal curvature measurement.

## METHODS

### Study Design

A repeated measures testing design, with 2 trials on each of 2 days, was used in this investigation. The intent of such a design was to assess day and trial variability of the HPSCI and/or the CV angle itself. Day and trial factors were controlled by the investigators. Groups were based solely on gender with no randomization necessary.

### Subjects

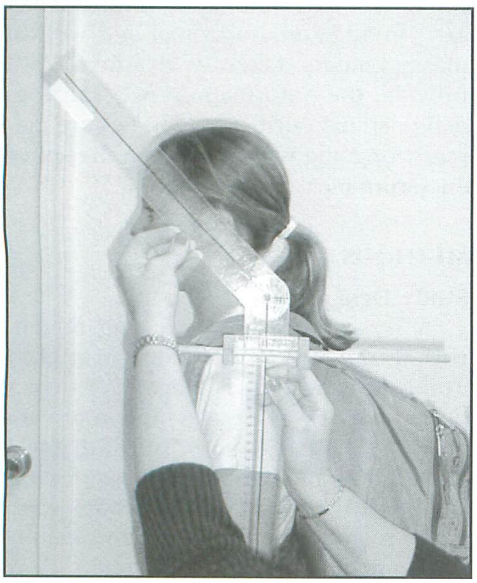
A convenience sample of 27 healthy elementary school-aged students between the ages of 9 and 10 was used. Prior to participation, the parents of the volunteers signed a consent form approved by Northeastern University's Human Subjects Committee. The rights of all individuals participating in the study were protected.

### Procedures

On each of the 2 experimental days, subjects reported to the testing area and were instructed to march in place 3 times. The subject then nodded his or her head 3 times to obtain orthoposition, which was then achieved by resting their head in a comfortable neutral position. Thus, the subjects determined their own neutral position. The rater took measurements of the subjects in a left sagittal view with the HPSCI. When necessary, the instrument was removed to facilitate measurement reading. Initially, the rater determined the location of the C7 spinous process by having the subject flex and extend the neck. This ruled out C6 by the absence of palpation on extension, leaving the C7 spinous process more prominent.[19]

The measurement taken with the instrument, HPSCI, was the CV angle (Figure 1). The rater aligned the axis/fulcrum of the instrument with the C7 spinous process in the left sagittal view. Next, the mobile arm of the HPSCI was aligned with the tragus of the ear and the stationary arm was aligned perpendicular to the floor. The alignment with the floor was confirmed with the line level that was attached to the proximal aspect of the arm. Once the arm was leveled, a measurement to the nearest degree was made and verbally stated to a recorder.

**Figure 1.**



After the initial measurement, a given subject left the testing area while CV angles were measured on additional subjects. Once a block of subjects was completed, a given subject immediately returned for a second measure. The intent of this design was to prevent unintentional bias on the part of the rater, limiting the ability to recall a subject's first trial when measuring CV angle on the second trial. The same procedures were repeated on a second test day within a 3-day period.

### Data Analysis

Two primary analyses were undertaken. A repeated measures analysis of variance was calculated to assess potential gender, day, and trial effects. Secondly, intraclass correlation (ICC) was calculated using a subjects x days x trials design. A probability level of $p < .05$ was selected as the threshold for significance.

**Table 1. ANOVA Output**

*Dependent Variable: CV Angle*

| Source | Sum of Squares | df | Mean Squares | F | Sig. |
|---|---|---|---|---|---|
| Group | 127.538 | 1 | 127.538 | 5.658 | .019 |
| Day | 21.616 | 1 | 21.616 | .959 | .330 |
| Trial | 7.477 | 1 | 7.477 | .332 | .566 |
| Group * Day | .875 | 1 | .875 | .039 | .844 |
| Group * Trial | .959 | 1 | .959 | .043 | .837 |
| Day * Trial | .183 | 1 | .183 | .008 | .928 |
| Group * Day * Trial | 5.22 | 1 | 5.22 | .232 | .631 |

## RESULTS

No significant day, trial, or interaction terms were revealed by ANOVA results as seen in Table 1. CV angle was significantly ($F=5.66$; $p=.019$) larger in girls (55.5°) than boys (53.3°). ICC was high in both gender groups. For girls, $R=.90$ ($R^2=.81$) with 76.6% of the variance due to subjects and $SE_{meas}=1.0$. For boys, $R=.92$ ($R^2=.85$) with 81.4% of variance due to subjects and $SE_{meas}=1.64$. See Table 2 for complete ICC data.

## DISCUSSION

The lack of significant day and trial effects, along with ICC values ≥ 0.9 suggest that the assessment of CV angle by the HPSCI is both consistent and stable across days and trials for a single rater. Clinically, this is clearly a relevant finding. A given clinician can reliably monitor CV angle from session to session with a small degree of error, and with little chance that the changes across the course of treatment are because of measurement error. This data is for school-aged children only. Current data collection and analysis is attempting to quantify HPSCI reliability across the lifespan. Furthermore, this study has only assessed intrarater reliability. In-house data suggest moderate to high interrater reliability as well. Additional data collection and analysis needs to be completed, however, to answer this question.

## CONCLUSION

This study indicates that a given clinician can reliably monitor head posture via the CV angle in school-aged children. This measurement can assist in gathering objective data during the evaluation and treatment of patients in the clinical setting. The HPSCI is one means of simply and objectively assessing the CV angle in the clinic. As we strive for more objective data upon which to base the practice of physical therapy, we can use means of measurements that are simple, yet effective, in the clinic in order to further support evidence-based practice in physical therapy. Studies that are currently ongoing with use of the HPSCI (for example, *Craniovertebral Angle Across the Lifespan and Craniovertebral Angle Following Backpack Loading*) exemplify the ease of such data collection.

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**Table 2. Intraclass Correlation Data**

| | Girls (n=16) | Boys (n=11) |
|---|---|---|
| **CV:** Overall Mean | 55.5° | 53.3° |
| Std Dev | 3.34° | 5.72° |
| Range | 47-60° | 40-60° |
| **CV:** Day1 | 54.9° | 52.9° |
| Day2 | 56.0° | 53.6° |
| Trial1 | 55.3° | 52.6° |
| Trial2 | 55.7° | 53.2° |
| **ICC:** R | .90 | .92 |
| $R^2$ | .81 | .85 |
| $SE_{meas.}$ | 1.04° | 1.64° |
| **% Total Variance:** | | |
| Subjects | 76.6 | 81.4 |
| Days | 9.4 | 10.7 |
| Trials | 14.0 | 7.9 |


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# Primary Care Educational Group Presents Inaugural Programming at CSM 2002 in Boston

Drs. Bill Boissonnault, Gail Deyle, and Joe Godges presented *Differential Diagnosis and Medical Screening in Physical Therapy* before 200 plus CSM participants in Boston on Saturday, February 23, 2002. The presentation focused on the physical therapist's effective identification of potentially serious medical conditions that mimic common musculoskeletal complaints. Emphasis was placed upon using data collected during the history and physical examination to screen for red flags initiating need for medical referral. Lecture and discussion were used to provide the physical therapists with a more comprehensive examination scheme. The information also provided insight into facilitating professional collaboration between physical therapists and physicians.

*The Guide for Physical Therapist Practice* outlines the physical therapist's role in Primary Care and the Orthopaedic Section's Strategic Plan supports the role of physical therapists as an entry-point into the health care delivery system. Given the APTA's definition of *Autonomous Practice*, physical therapists have the capability, ability, and responsibility to exercise professional judgment within their scope of practice, and to professionally act on that judgment. Furthermore, physical therapists have the professional capability and ability to refer to other professionals or to refer for diagnostic tests that would clarify the patient/client situation and enhance the provision of physical therapy services.

The Orthopaedic Section approved formulation of the Primary Care Educational Group in 2001. For more information on the Primary Care Educational Group, contact the Orthopaedic Section or Robert DuVall, PT, MMSc, OCS at reduvall@bellsouth.net.

# APTA House of Delegates

**Stephen M. Levine, PT, MSHA**

One person really can make a difference. All it takes is an idea. This is true in many areas of our lives—personal and professional. In our professional lives, it is all too common for us to think that we alone cannot make a significant difference in the direction or activity of the profession of physical therapy. However, there are so many physical therapists that have made a difference in the direction and impact both physical therapists and the American Physical Therapy Association (APTA) have had on our internal and external environments.

There are a variety of ways to make a difference in our profession. Most of us make a difference every day in the lives of patients and families under our care. For many of us, this is the primary reason we entered our profession. And it is a noble cause, to be sure. But there are times when the frustrations we encounter in simply trying to perform our jobs are too much for us individually to handle. Circumstances like the inability of our patients to obtain the needed care and equipment they require, payment policy limitations that prohibit appropriate reimbursement for services provided by or under the direction of physical therapists but allow for reimbursement of any so called *therapy service* provided *incident* to the physician, and the continual unilateral and arbitrary Medicare policies that treat those services provided by physical therapists differently than those provided by other health care professionals. Further, the idea that other individuals, including licensed health care providers and nonlicensed individuals, can provide *physical therapy* services and receive reimbursement for these services significantly limits the availability of appropriate reimbursement for services provided by qualified physical therapists, and significantly impairs the perception of the value of our services. Such issues seem monumental when looked at from the perspective of a physical therapist in an individual clinic or facility.

Members are the Association's single most important asset. Our professional organization is membership driven—members determine our activities and the direction of the APTA, and therefore the direction of the profession. The voice of a single physical therapist or physical therapist assistant can be multiplied to such a proportion as to become a position or policy of the APTA, and further, to effect public policy and government regulations. The House of Delegates (HOD) of the APTA is the highest policy-making body of our profession. It is the House of Delegates that this article will focus on, and how, as a member of the Orthopaedic Section, you can contribute significantly to your own future—and how you can make a difference.

> There are so many physical therapists that have made a difference in the direction and impact both physical therapists and the American Physical Therapy Association (APTA) have had on our internal and external environments.

As noted, the HOD is the highest policy-making body for the Association and for the profession of physical therapy. The House is a representative body, and therefore, the total size of the House, approximately 400 delegates, is apportioned based on the number of physical therapist and physical therapist assistant members in a state chapter. Delegates are elected at the state level based on this apportionment, and the position of delegate is a highly sought after one. The House of Delegates meets once a year, in June, in combination with the Annual Conference of the APTA. The House meets over a 3-day period; however, the preparations for each annual session take a significant amount of time. Most states begin preparing for the House in the fall, and at the national level, preparations for the House begin immediately after the close of the current House session.

The House is empowered to do almost anything with respect to our profession and Association, and sets the direction and priorities for activities of the Board of Directors and staff. Over the years, the House has made such decisions as moving all physical therapist professional education to the postbaccalaureate level; developed our Code of Ethics; developed a position on the role of the physical therapist in primary care; developed, modified, and adopted the mission, vision, and goals of the Association; and developed professional standards, policies, and positions on multiple practice-related issues. It is often these Association policies and positions that are passed by the House of Delegates that cause significant discussion and debate on a Chapter, Section, or small group level. Often, discussions revolve around such comments like "Why does the APTA have this policy?", "How does this policy affect me?", "Why did the House of Delegates do that?", or "Why did it take them so long to pass something like this?"

So, how does an idea from one individual or a group of individuals develop into an association policy or position? The process starts with an idea. To illustrate how the process works, an example pertinent to members of the Orthopaedic Section, APTA will be used, a position of the APTA entitled: Procedural Interventions Exclusively Performed by Physical Therapists (HOD 06-00-30-36). This position was adopted at the June, 2000 House of Delegates, and as a Position of the Association, is defined as *an approved opinion or judgment which APTA members are expected to support.* The Position reads as follows:

***It is the position of the APTA that:***
***The physical therapist's scope of practice as defined by the Guide to Physical Therapist Practice includes interventions performed by physical therapists. These interventions include procedures performed exclusively by physical therapists and selected procedures that can be performed by the physical therapist assistant under the direction and supervision of the physical therapist. Procedures that require immediate and continuous examination and evaluation throughout the intervention are performed exclusively by the physical therapist. Such procedural interventions within the scope of physical therapist practice that are performed exclusively by the physical therapist include, but***

***are not limited to, spinal and peripheral joint mobilization/manipulation, which are components of manual therapy, and selective sharp debridement, which is a component of wound management.***

This position statement did not start out in this format. The conceptual idea was generated by several components (Chapters, Sections and Assemblies of the APTA), including the Orthopaedic Section. Once an idea is generated, it is generally floated out at a Chief/Section/Assembly Delegates meeting, which takes place at the Combined Sections Meeting (CSM) in February. The merits of an idea can be discussed by those in attendance, and support or lack thereof can be ascertained. If a component wishes to pursue the conceptual idea, generally there is a call for those interested in working on the concept to continue dialogue at or after CSM. The idea is then further developed, and must be submitted to the Governance Office at APTA by the deadline set by the Speaker of the House, generally in mid-March. The conceptual framework must be submitted in a format defined by the Reference Committee (RC). The Reference Committee is a committee of the HOD whose function is to ensure that issues to be taken up by the HOD are consistent with the mission, vision, and goals of the Association. The RC also will make sure that the format of the idea is in suitable form as to be able to be debated by the HOD consistent with our parliamentary authority, *Robert's Rules of Order, Newly Revised*, 10th Edition.

The purpose of using Robert's Rules, as parliamentary authority, is often misunderstood, and a full discussion of this process is beyond the scope of this article. However, the general purpose is to enable the overall membership of an organization to establish and empower an effective leadership as it wishes, and at the same time to retain exactly the degree of direct control over its affairs that it chooses to reserve to itself.[1] Ultimately, it is the majority of delegates in the HOD who decide the general will, but only following the opportunity for a deliberative process of full and free discussion. It is the Reference Committee who assists in developing the conceptual idea into a main motion, which then allows it to be brought before the deliberative assembly (HOD) for discussion. The main motion is then assigned a number, which will cause it to be heard in the order prescribed by the RC. So, a particular motion will be assigned a number, such as RC 35-02, meaning it is the 35th order of business for the HOD session to be held in 2002. The ordering of motions is determined by the RC based on criteria developed specifically for this purpose. Once the RC meets at the end of March, all issues to be given previous notice to the general membership are then published in what is called *Packet 1*, and disseminated to all component leaders and delegates to the House of Delegates.

It is at this time, generally at the beginning of April, that our governance process seems to kick into high gear for most delegates. Briefing Papers are developed for each motion by APTA staff, for the purposes of providing important background and other pertinent facts, such as the fiscal impact of a particular idea, as well as other Association positions or policies that may be affected by adoption of the motion. In this way, delegates come to the HOD more prepared to do business, and more aware of the potential impact of their decisions.

Once on site, pre-House activities are organized to allow delegates from different components to have some preliminary discussions on the issues. Delegates are encouraged to have many of these discussions prior to arriving at the HOD; however, face-to-face contact often helps to resolve differing viewpoints that have not come to resolution previously. Once the HOD begins, motions are taken up in the order assigned by the RC, unless the HOD agrees to reorder the agenda, which it is entitled to do at any time. The Speaker of the House (Speaker) conducts the proceedings of the HOD in accordance with Association Bylaws, Standing Rules and our parliamentary authority. At the point in time in which a motion, say the one described above, is in order and open for discussion, the merits of the motion may be discussed for as long as the deliberative assembly chooses to discuss it. The Speaker makes an attempt to alternate debate between opposing viewpoints, so that discussion can flow and all views may be heard. Once the group has completed its discussion (or a delegate moves to stop debate on an issue), the motion is put to a vote. For most main motions, a majority vote of those present is necessary to adopt a motion. If adopted, the motion becomes an Association Policy, Position, Guideline, or Action that will be taken. If the motion is defeated, then the next order of business, in turn, is taken up, and the process begins again.

The governance process of our Association is a fascinating example of democracy at work—of the ability for those of differing viewpoints to come together, discuss, and debate an issue, often with passion, in an arena that allows for the majority to rule, but which requires the rights of the minority to be protected. It is through this democratic process, which is used by both English Parliament and the U.S. Congress, that the direction and positions of our Association and the profession are developed. It is often only after a source of frustration or lack of awareness that an issue is being discussed and acted upon does an individual realize that the activities of others can affect his/her own practice setting and professional career. It is often then that the question arises: "How can I get involved?" Although we are all extremely busy in our professional lives, the ability for us to develop and promote our own professional direction and destiny is something none of us should take for granted, nor is it something we should abdicate to others. It is through our House of Delegates that an individual can rise to the occasion and help chart the course for our professional future. I invite you to join your colleagues at the House of Delegates in Cincinnati in June and experience the democracy of your profession at work. One person really can make a difference.

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# 2002 CSM Award Winners

### Student Award

The purpose of this award is to identify a student physical therapist (first professional degree) with exceptional scholastic ability and potential for contribution to orthopaedic physical therapy. The eligible student shall excel in academic performance in both the professional and pre-requisite phases of his/her educational program, and be involved in professional organizations and activities that provide the potential growth and contributions to the profession and orthopaedic physical therapy.

**Todd Davenport** received his baccalaureate with distinction from Willam-ette University in Salem, Oregon. He will graduate in May of 2002 from the Doctor of Physical Therapy (DPT) program at the University of Southern California. The mission of the University of Southern California's DPT program is to educate authoritative practitioners and future leaders in the profession of physical therapy. Mr. Davenport embraced this mission wholeheartedly through his pursuit of excellence in the clinical arena and his voluntary involvement in rehabilitation science research. He was selected to complete a full-time internship at Rancho Los Amigos National Rehabilitation Center. In this clinical setting he demonstrated superb communication, interaction, and education skills with patients and colleagues. His research included participation in the development of reliable physical assessment tools to measure muscle fatigue in human subjects and in a second NIH-funded research project investigating the cellular mechanisms employed by anabolic steroids to affect neuromuscular function. Todd Davenport is truly an outstanding student, soon to become an insightful and well-educated practicing physical therapist with the tremendous potential to contribute to the Orthopaedic Section of the APTA.

### James A. Gould Excellence In Teaching Orthopaedic Physical Therapy Award

This award is given to recognize and support excellence in instructing orthopaedic physical therapy principles and techniques through the acknowledgement of an individual with exemplary teaching skills.

The instructor nominated for this award must devote the majority of his/her professional career to student education, serving as a mentor and role model with evidence of strong student rapport. The instructor's techniques must be intellectually challenging and promote necessary knowledge and skills.

**Kornelia Kulig, PT, PhD, FMAAOMPT** is the 2002 recipient of the James A. Gould III Excellence in Teaching of Orthopaedic Physical Therapy Award. Dr. Kulig is an Associate Professor of Clinical Physical Therapy at the University of Southern California and is Co-Director of the Orthopaedic Residency Program. In these capacities she is a teacher, mentor, clinician, and a clinical researcher, epitomizing the role of an academician in a professional program.

Dr. Kulig has a very strong appreciation for the basic sciences underlying practice. She holds a PhD in biomechanics from the Academy of Physical Education in Wroclaw, Poland and conducted her postdoctoral studies at the University of Iowa. Dr. Kulig is an active researcher. Her research and clinical endeavors have resulted in numerous publications in peer-reviewed journals of both findings from hypothesis-driven research and clinical case reports. It is this commitment to research supporting orthopaedic physical therapy that separates Dr. Kulig from her peers. Even in her research, Dr. Kulig demonstrates the ability to integrate science with practice. That is, her commitment to finding the evidence behind the practice of orthopaedic physical therapy forms the basis for her ability to present the elements of practice with the utmost objectivity and scientific merit.

Under Dr. Kulig's motivating guidance, students have pursued academic and clinical degrees. Many of the students are now exceptional clinicians, teachers, and researchers. Additionally, those who had the privilege of studying with Dr. Kulig praise her multidimensional view of learning and a wholehearted commitment to teaching and to the profession. The blend of experiential, anatomy and radiology laboratory sessions is an example of her unique approach to the teaching of analytical anatomy. Students in the professional programs praise her soft-spoken confidence, excitement, and expertise in orthopaedics and her discussion style as Socratic and stimulating. Students pursuing a research career speak to her scientific merit and her ability to create an environment where it is safe to take intellectual risks followed by thorough exploration of concepts.

With this Award, Dr. Kulig joins a group of distinguished faculty and mentors in orthopaedic physical therapy.

### Paris Distinguished Service Award

This award is given to acknowledge and honor a most outstanding Orthopaedic Section member whose contributions to the Section are of exceptional and enduring value. The nominee shall have made substantial contributions to the Section in areas such as: professional recognition and respect for the Section's achievements, and advanced public awareness of orthopaedic physical therapy.

The Orthopaedic Section is proud to honor **Nancy White, PT, MS, OCS** as the seventh recipient of the Paris Distinguished Service Award. Nancy White has been a member of the Orthopaedic Section since 1981, with 18 of those years marked by service to the Ortho-paedic Section. Nancy's many significant contributions were varied in nature, exceptional in quality, and enduring.

Nancy's tenure with the Orthopaedic Section began as a member of the Practice Committee in 1983, followed by chairing this important committee from 1986-1988. During this time she also chaired the Task Force on Supervision (1985-86). In 1989 Nancy joined the Education and Program Committee; she served 6 years including chairing the committee from 1992-1995. During this tenure Nancy assisted in the development of the Special Interest Groups' education programs, and helped develop Section continuing education courses such as the Review of Advanced Orthopaedic Competencies and the Home Study Course series. In 1995 Nancy was elected to the office of Vice President and re-elected in 1998. During these six years Nancy also chaired the Awards Committee, served on the Section's Advisory Panel for Home Study Courses, was the liaison to new Section

Special Interest Groups, and for three years was appointed to the Foundation for Physical Therapy's Board of Trustees as the APTA Sections' representative. She was instrumental in developing the Orthopaedic Section Mission and Vision and Strategic Plan (1997 and 2000), fostering the development and growth of the Section's new Special Interest Groups, helping to develop an organizational structure for the Home Study Course Program, and developing a strong relationship with other components and APTA.

Nancy's commitment to our profession extends beyond the Orthopaedic Section as evidenced by serving the Virginia Physical Therapy Association as District Chair, Chair of the Legislative Committee, Vice President, and President from 1983-1990. Currently, Nancy holds an adjunct faculty position at Marymount University and Howard University.

Nancy sees private patients at a clinic in Arlington, VA and is developing a physical therapy clinic at the Arlington Free Clinic. The development of this new clinic is being supported by a grant received by Marymount University. Lastly, throughout these years of exceptional service Nancy has done a wonderful job of balancing her professional and family life. Her even-keeled approach lends an air of stability and level-headedness that has served her well both professionally and personally.

### Rose Excellence in Research Award

The purpose of this award is to recognize and reward a physical therapist who has made a significant contribution to the literature dealing with the science, theory, or practice of orthopaedic physical therapy. The submitted article must be a report of research but may deal with basic sciences, applied science, or clinical research.

**Dan Riddle**, PT, PhD, is the recipient of the Rose Excellence in Research Award for the paper entitled, "Use of the SF-36 and SF-12 Health Status Measures: A Quantitative Comparison for Groups Versus Individual Patients" published in Medical Care 2001;39(8):867-878. The co-authors for this article are Kang Lee, MS, PT and Paul Stratford, MSc, PT. Dr. Riddle is currently an Associate Professor in the Department of Physical Therapy at Virginia Commonwealth University in Richmond Virginia. He received his Certificate in Physical Therapy from the University of Iowa, a Masters degree in Orthopedic Physical Therapy and his Doctoral degree in Education from Virginia Commonwealth University. Dan has served the Section in many capacities including Chairman of the Research Committee and member of the Task Force on Manual Therapy. He is also an Editorial Board Member for Physical Therapy. He has a consistent and extensive record of scholarly publications that have made a significant impact on the practice of orthopaedic physical therapy, particularly in the area of measurement and outcome assessment. He is richly deserving of this honor, and we extend warm congratulations to Dan and his colleagues on this excellent work.

ORTHOPAEDIC SECTION, APTA, INC.

# CSM BOARD OF DIRECTORS MEETING
# FEBRUARY 22, 2002
# BOSTON, MASSACHUSETTS

**MINUTES**

The 2002 CSM Board of Directors Meeting was called to order at 8:30 AM on Friday, February 6, 2002 by Michael Cibulka, President.

**ROLL CALL:**

Present:
Michael Cibulka, President
Lola Rosenbaum, Vice President
Ann Grove, Treasurer
Joe Farrell, Director
Gary Smith, Director
Paul Howard, Education Chair
Phil McClure, Research Chair
Steve McDavitt, Practice Chair
Bill Boissonnault, Immediate Past President
Randy Roesch, APTA Liaison
Terri DeFlorian, Executive Director

Absent:
None

Michael Wooden, Membership Chair
Susan Appling, OP Editor
Robert Johnson, OSC Chair
Joe Godges, Finance Committee Member (incoming treasurer)
Mary Ann Wilmarth, HSC Editor
Terry Randall, Public Relations Chair
Mary Milidonis, Nominating Committee Chair

11:00 AM - Noon
Debra Lechner, OHSIG President
Scott Minor, OHSIG Board member
Bonnie Sussman, OHSIG Vice President
Steve Reischl, FASIG President
Jennifer Gamboa, PASIG President
Jeff Stenback, PASIG Treasurer (incoming president)
Joe Kleinkort, Pain SIG President
Cheryl Riegger-Krugh, Animal SIG President
Pam White, Finance Committee Member

**ACTION ITEMS:**

The agenda for the 2002 Fall Board of Directors meeting was approved with one addition.

The minutes from the 2001 Fall Board of Directors conference call meeting were adopted with one addition.

=MOTION 1= Ms. Grove moved, "The priority for adding money back into the budget if and when it becomes available be prioritized as follows;

a. SIG prior year funds (OHSIG $26,041.14, FASIG $23,325.22, Animal SIG $17,419.19, Pain SIG $2,977.60)
b. Equipment for the Section office - $5,000
c. Foundation for Physical Therapy - $100,000
d. Benevolent giving to include but not be limited to PAC funding
e. Research grants - $15,000
f. President stipend - $5,000

This list will be revisited each year."
=ADOPTED=

=MOTION 2= Ms. Grove moved, "The Board of Directors form a task force to examine the structure, current policy and procedures, finances, lines of communication between the Board, SIGs, and education groups within the Section and report back to the Board within 60 days. The Board will finalize the report and bring back to the task force at Annual Conference. =ADOPTED=

=MOTION 3= Mr. McDavitt moved, "That the Section cosponsor the following position statement with APTA:

*Continuing Education for Individuals Other Than Physical Therapists and Physical Therapist Assistants*

It is the position of the American Physical Therapy Association that:

Physical therapists and physical therapist assistants conducting continuing education courses are obligated to indicate in the printed and lecture materials that such course material is not intended for use by licensed or regulated participants outside of the scope of their license or regulation.

Furthermore, they should make it clear when teaching elements of patient/client management that subsequent use of those elements is referred to as physical therapy only when performed by or under the direction and supervision of a physical therapist, in accordance with Association policies, positions, guidelines, standards, and ethical principles and standards.

Physical therapists and physical therapist assistants should not conduct continuing education courses that teach patient/client management to individuals who are not licensed or otherwise regulated, except as they are involved in a specific plan of care, and in accordance with Association policies, positions, guidelines, standards, and ethical principles and standards." =ADOPTED=

SS: This position addresses only individuals who are licensed or regulated, but does not include individuals who are not licensed or otherwise regulated. Physical therapists and physical therapist assistants do educate other health care professions, other practitioners, and families as an element of intervention for the purpose of providing information and teaching skills in specific elements of patient/client management. This education is not intended to prepare these individuals to perform patient/client management services, and should not be construed as disallowed by this position.

=MOTION 4= Mr. McDavitt moved, "The Orthopaedic Section, APTA sanction its Practice Committee to establish a plan including but not limited to an amendment or creation of the APTA position statement addressing a licensure exemption or reciprocity clause in State Practice Acts for enabling PTs to have temporary limited interstate practice privileges without additional required licensure and to bring forth an RC to the 2002 HODs." =ADOPTED=

The following RC on interstate reciprocity is being proposed by the Orthopaedic Section:

It is the position of the APTA that: The APTA supports the inclusion of exemptions in physical therapy practice acts for physical therapists licensed in one jurisdiction in the United States but who are temporarily providing patient/client management to individuals affiliated with or employed by established athletic teams; athletic corporations; or performing arts companies training, competing, or performing in another jurisdiction.

SS: Due to continual state-to-state travel which defines a team, athletic organization, or performing arts company on tour, the logistics of establishing relationships with local health care networks and added licensure make efficient care difficult and costly for such temporary conditions. This position provides a more efficient cost management for these individuals.

=MOTION 5= Mr. Farrell moved, "Janet Probish Dolot be appointed as the Section liaison to the APTA Student Assembly." =ADOPTED=

=MOTION 6= Ms. Grove moved, "Reappoint Lola Rosenbaum to a 2-year term and Gary Smith to a 3-year term on the JOSPT Board of Directors." =ADOPTED=

=MOTION 7= Mr. Farrell moved, "Appoint Michael Wooden for another 2-year term as Membership Chair to get back in sync with the rest of the committee chair appointments." =ADOPTED=

The Board of Directors, by consensus, approved the appointment of Jay Irrgang as Research Chair.

=MOTION 8= Mr. Farrell moved, "The Annual Conference face-to-face Board Meeting be replaced with a conference call meeting for 2002 only. The conference call meeting will be Monday, June 3 from 9:00 AM CST - 2:00 PM CST." =ADOPTED=

The Board of Directors, by consensus, approved to discontinue pursuit of developing a JOSPT award.

The Board of Directors, by consensus, approved the Governance Task Force Conference Call minutes, February 1, 2002 with one editorial change.

The Board, by consensus, approved funding the following individuals to CSM, AC, and Fall meetings -

| | | |
|---|---|---|
| A. | CSM | Board of Directors, Committee Chairs, SIG presidents, Education Vice Chair |
| B. | AC | Board of Directors |
| C. | Fall | Board of Directors, Committee Chairs, one SIG member to represent all SIGs (one representative of each SIG will be funded to attend the Fall Strategic Planning meeting every 3 years) |

The Finance Committee will revisit this policy annually.

=MOTION 9= Ms. Rosenbaum moved, "The Orthopaedic Section donate 10 HSCs to the Orthopaedic Specialty Council Item Writers. The Item Writer may choose a HSC from 98.1-11.1. =ADOPTED=

ADJOURNMENT 8:00 PM

ORTHOPAEDIC SECTION, APTA, INC.

# CSM 2002 ANNUAL MEMBERSHIP MEETING BOSTON, MASSACHUSETTS FEBRUARY 23, 2002

## I. CALL TO ORDER AND WELCOME – President, Michael Cibulka, PT, MHS, OCS

## II. BOARD OF DIRECTOR REPORTS

A. President – Michael Cibulka, PT, MHS, OCS
The agenda was approved as printed.

The business meeting minutes from CSM in San Antonio, Texas February 17, 2001 were approved as printed in Volume 13:1:01 issue of *Orthopaedic Physical Therapy Practice.*

B. Vice President/Awards Committee Chair – Lola Rosenbaum, PT, MS, OCS

1. The Awards Committee members were recognized and thanked for their contributions.
2. Nancy White was recognized as this year's Paris Distinguished Service Award winner.
3. Kornelia Kulig was recognized as the James A. Gould, III Excellence in Teaching Award winner.
4. Todd Davenport was recognized as the Outstanding Physical Therapy Student Award winner.

C. Treasurer – Ann Grove, PT

1. Special thanks was given to the Finance Committee members for all their hard work over the past year.
2. As of December 31, 2001 the actual income received was $1,206,403.
3. As of December 31, 2001 actual expenses were $1,156,935. This does not include the cost of running JOSPT, non-operating expenses, and losses from investments.
4. Money was taken out of the reserve fund early in 2001 to pay off some of our debt. This along with the market decline caused a drop in our reserve fund below our current policy of 70% of one year's operating expenses in reserves.
5. At the end of 2001 the Section took out a line of credit in the amount of $170,000 to pay off our prior commitments. To date all of our past commitments have been paid in full.
6. The Section has an outstanding commitment of $100,000 that needs to be paid to the Foundation in 2002.
7. The Section approved a deficit budget for 2002.
8. The Board adopted a list prioritizing where money will go when the Section has more than they currently need. First on that priority list is the SIG prior year funds.

D. Director – Joe Farrell, PT, MS

1. Joe serves as liaisons to the Membership, Practice, and Public Relations Committees; AAOMPT; and the Manual Therapy Education Group.
2. Joe is responsible for reviewing the Section's bylaws. A new bylaws committee has been formed with Steve McDavitt as Chair. The committee is charged with reviewing the Section bylaws in detail and presenting recommendations to the Executive Committee by May 1. A major potential change is adding a President Elect position and eliminating the immediate past president position.
3. Other responsibilities include reviewing the Board of Director job description and working with the APTA credentialing committee on orthopaedic physical therapy practice.

E. Director – Gary Smith, PT, PhD

1. Gary serves as liaisons to Publications, PTA Education Group, Foot and Ankle, SIG, Pain Management SIG, and Performing Arts SIG.
2. Gary was appointed along with Lola Rosenbaum to the JOSPT Board of Directors.
3. Gary is a member of a task force to examine the structure, current policy and procedures, and lines of communication between the Board, SIGs, and Education Groups within the Section, and how to appropriately deal with SIG finances. The task force is to report back to the Board the beginning of April 2002.
4. Other activities included participating in a Governance Task Force to look at the purpose and meaning of meetings and how they fit with the Section's budget schedule as well as comparing the Section bylaws with APTAs.

F. Education – Paul Howard, PT, PhD, Cert MDT

1. The SIG and Education Group program chairs as well as Stefanie Synder, Program Coordinator for the Section, and the Education Committee Vice Chair were thanked for all their hard work in making this CSM a success. The Board Liaison to Education was also recognized.
2. Plans are already underway for CSM 2003 programming in Tampa, Florida.
3. Paul was charged by the Board to review the Practice Analysis Guidelines, obtain input from officers, committee chairs, and SIGs and present to the Board for comments.

G. Research – Philip McClure, PT, PhD

1. Committee members were acknowledged and thanked for the time they put in reviewing poster and platform submissions for CSM 2002.
2. There was an overwhelming response again this year for poster and platform submissions. The Committee reviewed 168 abstracts.
3. The Committee continues to receive grant proposals to review, which have been of good quality.
4. Support of the Foundation for Physical Therapy continues to be strong.
5. The Research Committee selected and the Board approved Dan Riddle as this year's Rose Excellence in Research Award winner.
6. This is Phil's last meeting as Research Chair. Taking his place will be Jay Irrgang.

H. Practice – Steve McDavitt, PT, MS

1. This is a member driven committee and the committee works very hard to address the needs of members. If you believe there are concerns the committee is not addressing please contact the committee.
2. Members can e-mail Steve to request a copy of the manipulation document and the Take Action Packets.
3. The AAOMPT donated $3,000 to a fund to help APTA in their suit against the Chiropractors on mobilization and manipulation. Steve was one of APTA's witnesses in this suit.
4. In 1999 the Section Board approved a position statement on education. This year the Section is cosponsoring a position statement with the APTA (See page 20 & 21 of the CSM Board of Directors Meeting minutes).

5. The Board adopted a motion to bring forth for following RC on interstate reciprocity to the 2002 House of Delegates (See page 21 of the CSM Board of Directors Meeting minutes).

## III. COMMITTEE REPORTS

A. Membership - Michael Wooden, PT, MS, OCS

1. Committee members were thanked as well as Linda Calkins, Tara Fredrickson, and Sharon Klinski from the Section office for their work throughout the past year in serving our members.
2. Overall membership is up 1.6-1.7% over last year, which is just under our goal of increasing membership by 2% each year.
3. A survey is now on the web site and also in this issue of *OP* to assess the needs of members, specifically the PTAs and students since these are the membership classes that have decreased over the past couple of years.
4. The Board approved the creation of a new position within the Section titled Liaison to the APTA Student Assembly. Janet Probish Dolot was appointed the first liaison. The Section office and Finance Committee will work with Janet on defining the role of this position. The Section sees this move as an investment in our future, to retain students as members after they graduate.

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

1. The Advisory Council along with Sharon Klinski, Managing Editor, were thanked for all their hard work over the past year.
2. The special issue that is coming out in June will focus on Performing Arts Physical Therapy.
3. Submissions are always encouraged from members. *OP* is not a peer-reviewed publication. Clinical articles are welcome.

C. Orthopaedic Specialty Council - Robert Johnson, PT, MS, OCS
(Michael Cibulka reported in Robert's absence)

1. The Council is redoing the DACP which will be renamed the DSP, Description of Specialized Practice. The DSP will be completed in March 2002.
2. Over 400 new orthopaedic specialists were certified in 2001.
3. It was communicated to the Specialty Council that the Orthopaedic Section home study courses are a tremendous help in preparing for the OCS exam.
4. Rob Landel will be replacing Michael Cibulka on the committee in July.

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

1. Thanks were given to the office staff for all their help as well as the Public Relations Committee members.
2. A new activity the committee is pursuing is to try and get a physical therapist as a speaker on the program at the Nurse Practitioner and Physician Assistant conferences. This would take the place of having a physical therapist at these meetings to only man our display booth. The committee is writing up a policy on this to include paying honorariums which will be brought to the Executive Committee for review on their March 19 conference call.

E. Nominations - Mary Milidonis, PT, MMSc, OCS

1. A thank you went out to all those individuals who were willing to serve over this past year.
2. The Nominating Committee members were thanked for their work over this past year. Bill O'Grady will be the committee chair for 2002.
3. The election results for 2001 are: Gary Smith, Director; Joe Godges, Treasurer; and Susan Michlovitz, Nominating Committee Member.
4. The election return rates were up this year. We had a 16% return rate for our president election.
5. This year we are looking to fill the positions of Director and one Nominating Committee Member. A call for nominations from the floor was given. Liza Hatch was nominated for the position of Nominating Committee member.

F. JOSPT - Guy Simoneau, Editor-in-Chief

1. Guy is the new editor of JOSPT. He has had 10 years of experience with JOSPT as a reviewer, and editorial board member, and now as Editor.
2. There have been some major changes with the Journal over the past 7 months. The office moved from La Crosse, WI to Alexandria, VA, the office staff is new, publishers have changed, there is a new editor, and the editorial board is being restructured.
3. Guy has 3 goals for JOSPT: (1) to remain the number one journal in rehabilitation and maintain a high ranking in orthopaedics and sports, (2) have a timely review process, and (3) increase the number of manuscripts that are submitted.
4. The Section recognized Guy as a past winner of the James A. Gould III Excellence in Teaching Award. Guy was out of the country at the time he received this award and was never officially recognized.

## IV. SPECIAL INTEREST GROUPS

A. Occupational Health - Deborah Lechner, PT - President

1. The SIG is in the process of planning a research retreat and a home study course.
2. A preconference course was held at CSM with over 60 attendees.
3. A task force was developed by the Section Board to address the issue of how to handle SIG funds.

B. Foot and Ankle - Steve Reischl, PT, DPT, OCS - President

1. Members of the SIG were thanked for their work over the past year.
2. The SIG is currently involved in planning their CSM programming for 2003.

C. Performing Arts - Jeff Stenback, PT, OCS - President

1. Jeff is the new president of the PASIG.
2. The SIG is undertaking a practice analysis and they are currently half way through the process. They anticipate being done with their DSP by February of 2003.
3. The SIG now has a network of performing arts physical therapists in each state.
4. There are 8 articles for the special issue of *OP* on performing arts that will be coming out in June.
5. Increasing communication with groups outside of the Orthopaedic Section is being pursued.
6. A preconference course is being planned for CSM 2003.

D. Animal - Cheryl Riegger-Krugh, PT - President

1. Members of the SIG were thanked for the work they did in 2001. There are currently 547 members in the Animal Physical Therapist SIG.
2. The SIG is actively working with the APTA on creating a liaison to the American Veterinary Medical Association.
3. The first retreat of the SIG was held in 2001.
4. The SIG is pursuing a research-based practice for animal physical therapy in order to achieve certification as an animal physical therapist.

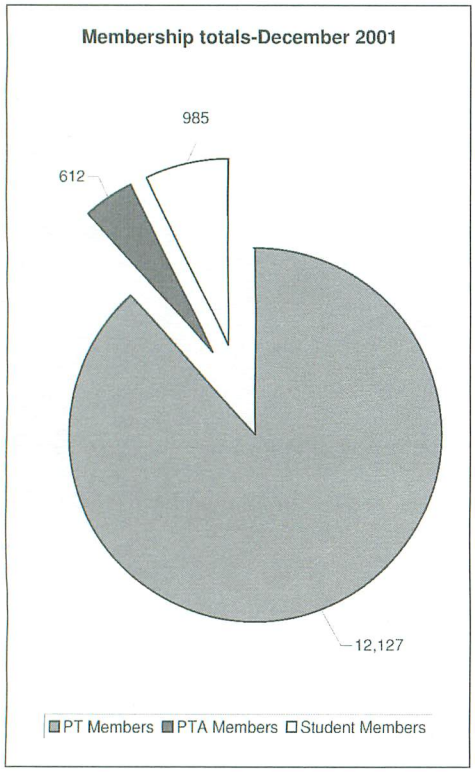
## V. NEW BUSINESS

A. =MOTION 1= The Board of Directors/President appoint a task force to contact and work with the Sports Section and the Hand Section to look into the pros and cons of merging the Orthopaedic, Sports, and Hand Sections and report back to the Section with a report at CSM 2003.=ADOPTED=

B. =MOTION 2= The Section convene a task force to address strategic planning for revenue generation for the Section - areas for consideration should include but not be limited to innovative member services that will generate revenue, an aggressive plan to sell our land, and a plan for financial relationships between the SIGs and the Section.=ADOPTED=

ADJOURNMENT 10:30 AM

## MEMBERSHIP




*Michael Wooden, PT, MS, OCS*
*Membership Chair*

## EDUCATION/PROGRAMMING COMMITTEE

The Education Committee is currently involved with reviewing and revising the Practice Analysis Grant Application and process. We thank Joe Godges for his extremely helpful input.

We had a very successful CSM 2002 in Boston (February 20-24), with over 5,200 attendees. The orthopaedic programming covered a wide spectrum of topics and all sessions were well attended. I would like to thank all of the SIG and Education Group Program Chairs for their hard work over the past year in putting together the many outstanding programs: Mark Cornwall (Foot & Ankle), Joe Kleinkort (Pain), Lynn Medoff (Performing Arts), Kris Heinrichs (Animal PT), Bonnie Sussman and Ray Vigil (Occupational Health), Gary Shankman & Terry Trundle (Orthopaedic PTA), Patty Zorn (Manual Therapy), Chris Powers (Patellofemoral) and Bob DuVall (Primary Care). The preconference course cosponsored by the Occupational Health SIG was also a big hit. The title of the course was *Office Ergonomics: The Basics and Beyond.* A special thank you to Bonnie Sussman for organizing and presenting this course. Thanks to all of our other speakers who presented outstanding programs!

I would also like to say thanks to Stefanie Snyder at the Section office who worked extremely hard over the past year taking care of the many details that make our orthopaedic programming and social events possible at CSM.

For the first time this year we put the CSM program handouts on the Section website www.orthopt.org. Attendees could download and print the handouts of presentations they planned on attending before they left for CSM. Check out our website for handouts that you may have missed. The handouts will be available on the website for 2 months following CSM 2002. Also, audiotapes are available for most presentations and can be obtained by contacting Sound Images, Inc. at (303) 649-1811 or on their website (orders@soundimages.net).

The Education Committee is already hard at work planning for CSM 2003, which will be held in Tampa from February 12-16. Contact me immediately if you have any programming ideas.

*Paul D. Howard, PT, PhD, Cert MDT*
*Education/Programming Chair*

## RESEARCH COMMITTEE

We are pleased to award this year's Rose Excellence in Research Award to Dan Riddle PhD, PT, Kang Lee MS, PT and Paul Stratford MSc, PT for the paper entitled, *Use of the SF-36 and SF-12 Health Status Measures: A Quantitative Comparison for Groups Versus Individual Patients* published in *Medical Care* 2001; 39(8):867-878. This was an excellent paper dealing the use of two widely used outcome measures and these authors should be congratulated on their excellent work.

We once again received an excellent response for platform and poster presentations. We received 84 abstract submissions for platform presentations and 64 were accepted including 8 case reports. Time slots were shortened from 20 minutes to 15 to accommodate more presenters. There were also 84 abstracts submitted for posters and 52 were ultimately accepted due to space constraints. These numbers are a slight increase over last year and the quality remains generally high. Committee members deserve credit for conscientiously dealing with this high volume of abstracts in a brief period. It is difficult at best to make judgments about quality based on only an abstract.

There were a total of 10 proposals submitted this year for the Clinical Grants program (2 for $5000 and 8 for $10,000). These proposals are currently under review. Due to fiscal restraints only one award at each level will be made this year for a total of $15,000.

The Section has continued to support musculoskeletal clinical research with the Foundation for Physical Therapy through funding of $40,000 grants.

I will be stepping down as chair after CSM and I am deeply grateful for the opportunity to work with such a talented group of individuals over the years, both on the Board and the Research Committee. Your commitment to the Section and our profession is truly inspiring. Jay Irrgang will be taking over as Research Committee Chair and I am confident he will provide excellent leadership and vision for the section's research goals in the years ahead.

*Phil McClure, PT, PhD*
*Research Chair*

## FINANCE COMMITTEE

*(see Figures 1 and 2)*

## HOME STUDY COURSE

The following are upcoming courses:

### 2002 Courses

HSC 12.1, *Prosthetics and Orthotics* (January–June 2002)

HSC 12.2, *Selected Diagnoses for Orthopedic Physical Therapy* (July–December 2002)

### 2003 Courses

HSC 13.1, *Including the Patient in Therapy: The Power of the Psyche* (January–June 2003)

HSC 13.2, *Evidence-Based Practice for the Upper and Lower Quarter* (April–September 2003)

HSC 13.3, *Physical Therapy for the Cervical Spine and Temporomandibular Joint* (July–December 2003)

Although some registrations for the HSC are received on-line, the direct mailings appear to be the most popular

means of registering for courses.

I would like to take this opportunity to express my appreciation for many people who have been involved with the Home Study Courses. Many thanks go to Darlene Aberg and all those at the Orthopaedic Section office for their work in organizing and designing the booth for CSM, and to Stefanie Snyder and the members who helped out at the booth during CSM in Boston. I would like to express my sincere gratitude to the HSC Advisory Panel for their input and support over the past year. In addition, Kathy Olson has done a great job as Managing Editor at the office in LaCrosse.

We hope that you continue to enjoy the Home Study Courses and as always we welcome new ideas and encourage authors to contact us at any time.

*Mary Ann Wilmarth, DPT, MS, OCS, MTC, Cert MDT*
*HSC Editor*

**PUBLIC RELATIONS COMMITTEE**

*Component Leadership Seminar:* Rick Watson, PR Committee member, attended the Component Leadership Seminar. The focus of this seminar was on membership and public relations. The APTA has changed the emphasis of their PR program away from using direct marketing to the consumer, which is very expensive. Our advertising will now be focused on the groups, which restrict our practice, such as insurers, purchasers, and legislators.

*Advisory Panel on Public Relations.* I attended the APTA Advisory Panel for Public Relations meeting in June. We met with the Membership Development Task Force to develop ways to use marketing and PR to enhance membership. We were also able to preview the movie that APTA has developed, which has been made available to all members, to use for PR.

*Exhibit Booth:* I displayed the exhibit booth in Chattanooga TN for the American Society of Orthopaedic Physician's Assistants conference. I met with Hal Blank, who is the president elect of ASOPA, to explore other opportunities to reach their members. I hope to have the opportunity to attend some of the business meeting as a liaison. The physician assistant is an important referral source for our profession and from my experience very open to communication and exchange of ideas, on both the clinic and professional levels.

In October I attended the American College of Nurse Practitioners conference in Atlanta. This has developed into another great opportunity to educate potential referral sources. In addition to the exhibit booth, I was an instructor in their Learning Center.

*Speaker Request:* During the past few years I have found promoting the profession is more effectively done by sharing clinical information as a speaker on their educational agenda, rather than from the exhibit hall. To enhance the effectiveness of our PR efforts the Orthopaedic Section will soon provide an honorarium to members of the Orthoapaedic Section who present educational programming at

**Figure 1. Finance Committee Income Report.**

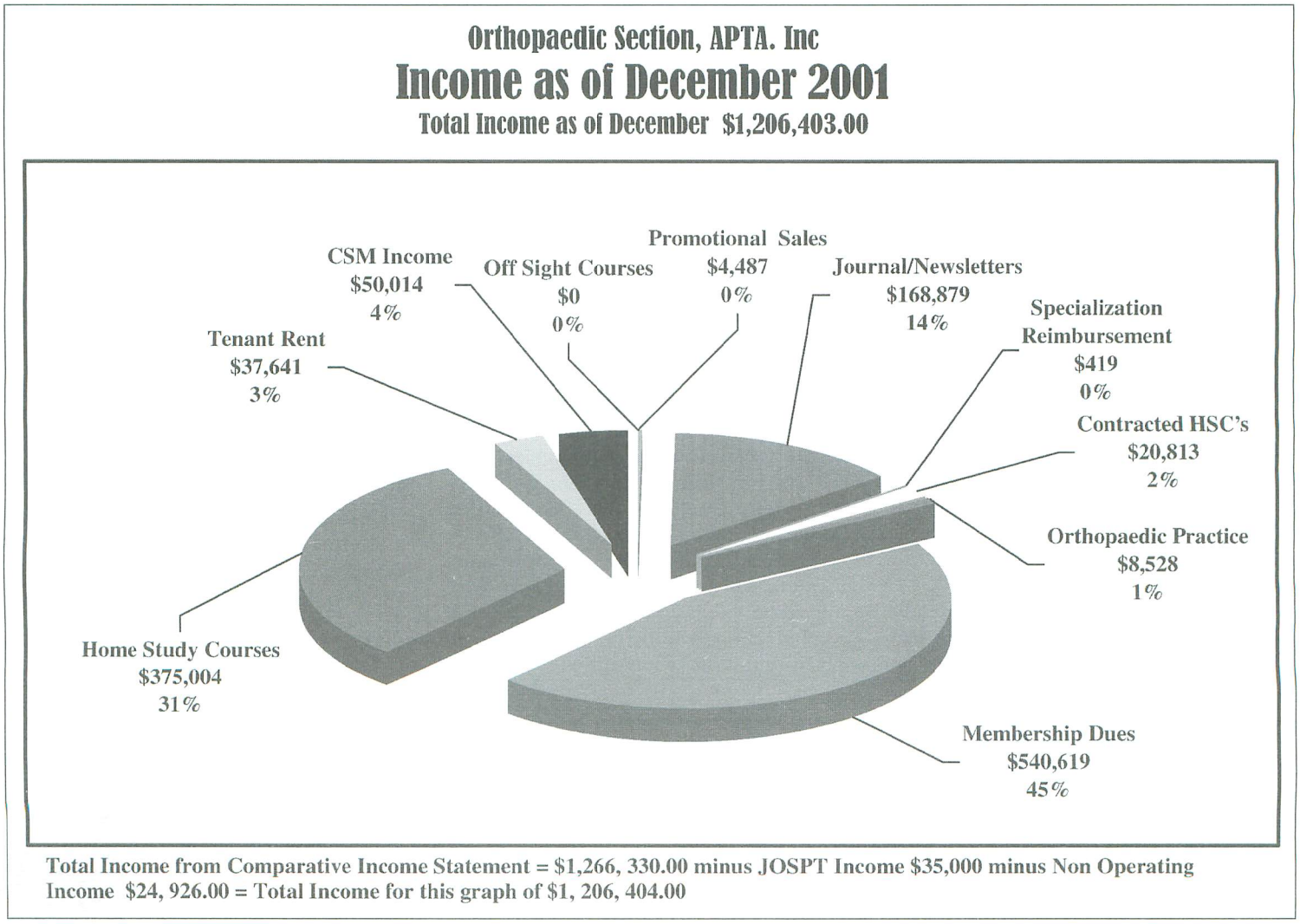
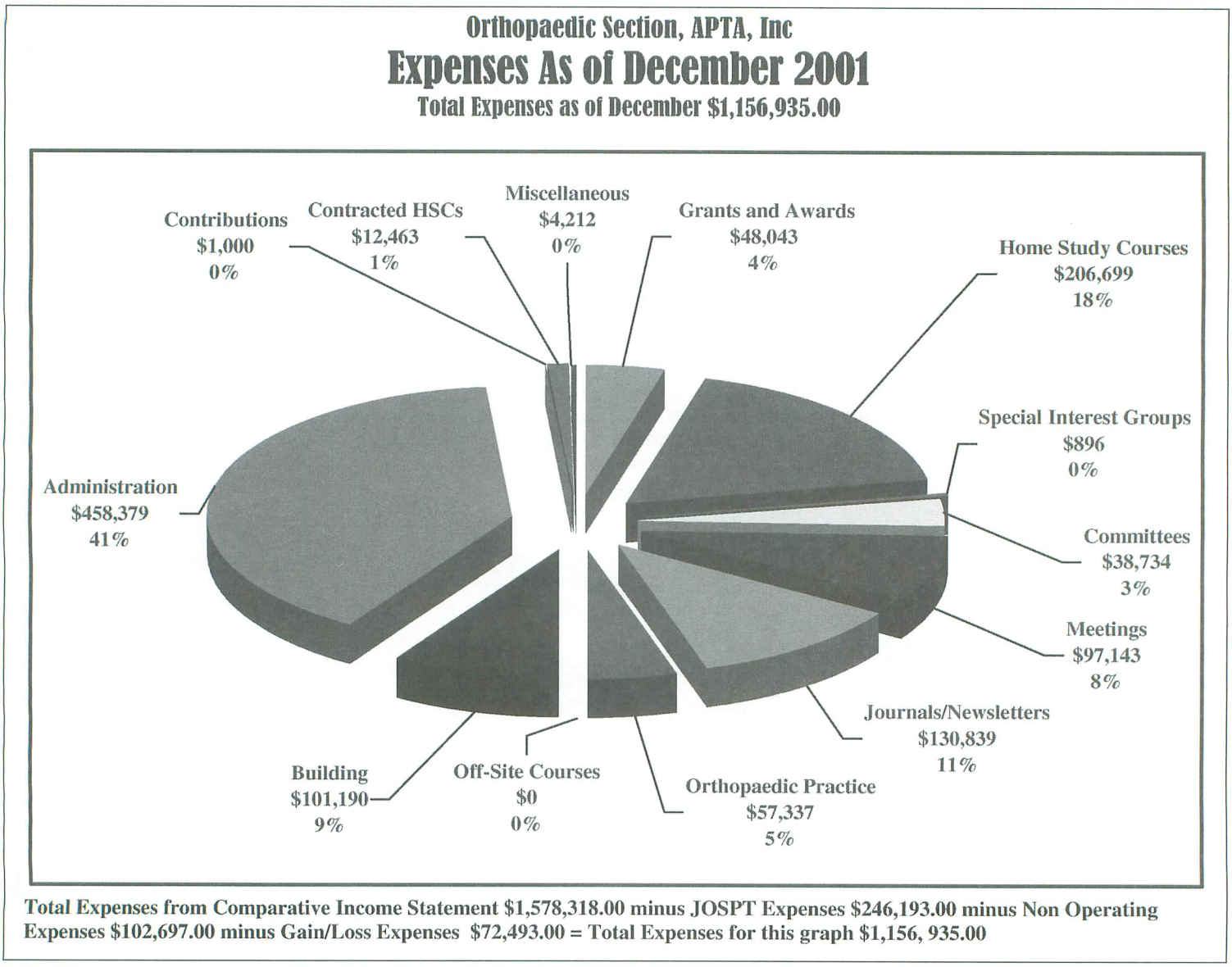


Figure 2. Finance Committee Expense Report.




**Total Expenses from Comparative Income Statement $1,578,318.00 minus JOSPT Expenses $246,193.00 minus Non Operating Expenses $102,697.00 minus Gain/Loss Expenses $72,493.00 = Total Expenses for this graph $1,156, 935.00**

other health care organization's national meetings. The amount of the honorarium would be in a range from $100 to $500, depending on the topic and length of the presentation.

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

**NOMINATING COMMITTEE**

Many thanks go out to all those individuals who were nominated to serve the Orthopaedic Section. We are fortunate to have many capable individuals willing to be a part of the process. It is truly a testament to the strength of the Orthopaedic Section. Congratulations and best wishes go out to the members elected in Fall 2001: Director, Gary Smith; Treasurer, Joe Godges; and Nominating Committee Member, Susan Michlovitz.

Thanks to the membership for taking an increased interest this year we were able to double last year's voting rate. Fall 2002 elections will be for 1 Director and 1 Nominating Committee member. Please contact the Section if you wish to nominate anyone or if you wish to run for office by May 1, 2002.

The Nominating Committee was also pleased to nominate 12 different members for National APTA office this year.

Bill O'Grady will serve as the Orthopaedic Section Nominating Committee Chair this year. It has been a pleasure serving the Section.

*Mary K. Milidonis, PT, MMSc, OCS*
*Nominating Committee Chair*

# Attention all Section Members and Student Members

In response to its long-term strategic plan, the Section is committed to serving YOUR needs and expectations as members.

**WE NEED YOUR INPUT!!!**

The revised Member Needs Survey is **your opportunity** to voice your opinion, and to let us know how to serve you better. Your answers to these items will provide the Section Board, Membership Committee, and office staff the information necessary to improve services to meet your needs as Orthopaedic Section members.

Please take 10 minutes to complete the survey. Mail or fax it by May 15, 2002 and you will be eligible to win a **YEAR's FREE SECTION DUES.**

Please check or write in the appropriate responses:

Name_____ APTA member number _____

1. Gender: Female Male

2. Age in years _____

3. Which best describes your ethnic origin:
   1. American Indian/Alaskan Native
   2. African American/Black
   3. Hispanic/Latin American
   4. White/Non-Hispanic
   5. Asian/Pacific Islander
   6. Other

4. State of Residence _____

5. Membership Category:
   1. PT 2. PT student 3. PTA 4. PTA student

6. If 35 hours per week defines *full-time*, which one of the following describes your current employment status?
   1. Full-time salaried
   2. Part-time salaried
   3. Full-time self employed
   4. Part-time self employed
   5. Retired
   6. Not working or seeking work
   7. Not working/seeking fulltime employment
   8. Not working/seeking part-time employment

7. Which of the following best describes your facility?
   1. Acute care hospital
   2. Subacute rehab (in-patient)
   3. Health system or hospital-based outpatient facility
   4. Private outpatient office or group practice
   5. Skilled nursing/extended or intermediate care facility
   6. Industry
   7. Home care
   8. School system
   9. Academic institution
   10. Health and wellness facility
   11. Research center
   12. Other

8. Which of the following best describes your current primary position?
   1. Sole owner of PT practice or business
   2. Supervisor/director of PT
   3. Senior PT
   4. Partner in PT practice or business
   5. Academic administrator/director of PT/PTA educational program
   6. Academic faculty member
   7. Staff PT
   8. Staff PTA
   9. Researcher
   10. Consultant
   11. Other

9. How long have you been a member of the Orthopaedic Section?
   1. Less than 2 years 2. 2-5 years 3. 5-10 years 4. 10-15 years 5. more than 15 years

10. How important were the following factors in your decision to join the Orthopaedic Section?

| | Very imp. | Important | Little imp. | No factor |
|---|---|---|---|---|
| Section Mission and Vision | _____ | _____ | _____ | _____ |
| JOSPT Subscription | _____ | _____ | _____ | _____ |
| Orthopaedic PT Practice Subscription | _____ | _____ | _____ | _____ |
| Annual Business Meeting | _____ | _____ | _____ | _____ |
| Programming at CSM and Annual Conference | _____ | _____ | _____ | _____ |
| Special Interest Groups | _____ | _____ | _____ | _____ |
| Obtaining Specialist Certification (OCS) | _____ | _____ | _____ | _____ |
| Discounts on Educational Courses | _____ | _____ | _____ | _____ |
| Discounts on Home Study Course | _____ | _____ | _____ | _____ |
| Research Grants | _____ | _____ | _____ | _____ |
| Discounts on Promotional Items | _____ | _____ | _____ | _____ |
| Section Website | _____ | _____ | _____ | _____ |

11. For the previous factors, indicate whether each has met your expectations:

| | Yes | No | Unsure | N/A |
|---|---|---|---|---|
| Section Mission and Vision | _____ | _____ | _____ | _____ |
| JOSPT Subscription | _____ | _____ | _____ | _____ |
| Orthopaedic PT Practice Subscription | _____ | _____ | _____ | _____ |
| Annual Business Meeting | _____ | _____ | _____ | _____ |
| Programming at CSM and Annual Conference | _____ | _____ | _____ | _____ |
| Special Interest Groups | _____ | _____ | _____ | _____ |
| Obtaining Specialist Certification(OCS) | _____ | _____ | _____ | _____ |
| Discounts on Educational Courses | _____ | _____ | _____ | _____ |
| Discounts on Home Study Course | _____ | _____ | _____ | _____ |
| Research Grants | _____ | _____ | _____ | _____ |
| Discounts on Promotional Items | _____ | _____ | _____ | _____ |
| Section Website | _____ | _____ | _____ | _____ |

12. Please rank these factors according to their importance to you (10 = most important; 1 = least)

| | | | |
|---|---|---|---|
| Section Mission and Vision | ___ | Obtaining Specialist Certification(OCS) | ___ |
| JOSPT Subscription | ___ | Discounts on Educational Courses | ___ |
| Orthopaedic PT Practice Subscription | ___ | Discounts on Home Study Course | ___ |
| Annual Business Meeting | ___ | Research Grants | ___ |
| Programming at CSM and Annual Conference | ___ | Discounts on Promotional Items | ___ |
| Special Interest Groups | ___ | Section Website | ___ |

13. Have you contacted the Section for advice or service? Yes No
    If yes, rate your experience (5 = excellent; 1 = poor) for the following:
    Courtesy
    Timeliness of response
    Accuracy of response

14. Do you think Section membership benefits are adequate considering the dues you pay? Yes No
    If no, why not? _____

15. Do you plan to renew your membership? Yes No
    If no, why not? _____

    1 Cost of dues
    2 Not working primarily in orthopaedic PT
    3 Publications not meeting my needs
    4 Educational programs not meeting my needs
    5 Home study courses not meeting my needs
    6 The Section is not meeting my needs (explain briefly) _____

16. If you are a student member, do you plan to continue Section membership after graduation? Yes No
    If not, why not?
    1 Cost of dues
    2 Not working primarily in orthopaedic PT
    3 Publications not meeting my needs
    4 Educational programs not meeting my needs
    5 Home study courses not meeting my needs
    6 The Section is not meeting my needs (explain briefly) _____

17. Do you have any suggestions to encourage more participation in Section sponsored activities?

18. Do you have any other information or opinions you would like to share with the Section Board of Directors and Membership Committee?

Thank you for your time and valuable feedback.

Fax your responses to 608-788-3965, or mail to:

Orthopaedic Section, APTA
2920 East Avenue South, Ste 200
La Crosse, WI 54601

# Occupational Health Physical Therapists Special Interest Group

## Orthopaedic Section, APTA, Inc.

Spring 2002 Volume 14, Number 1


**President's Report**

*Deborah Lechner, PT, MS*

The first year of the new century was one that most of us will never forget. September 11, 2001 has altered our lives forever. In some ways it has made our lives more challenging, especially for those of us who travel frequently for work. In some ways it has made life a lot more uncertain. In other ways it has brought Americans from all walks of life closer together for a common cause, as adversity often does. Our professional association and its affiliates have not been immune to the fall-out that has rocked our national economy. This year has been one of *plans on hold* for the Occupational Health SIG, despite our best efforts to accomplish our goals. As you will see from reading the following report, several of our major initiatives could not begin due to budgetary issues. However, dealing with these challenges is leading us to develop more clear lines of communication with the Orthopaedic Section BOD and more specific policy for the handling and distributing of funds earned by the SIGs. Here are some of the highlights:

***Changes in Board of Directors Meetings for 2001:*** To assist the Orthopaedic Section in trimming the budget, we eliminated 2 face-to-face meetings this year (at annual conference and our annual retreat). Instead of these face-to-face meetings we have held telephone conferences. This approach has turned out to be adequate primarily due to the competency and dedication of our Board members.

***OHSIG Newsletter:*** Our secretary, Karen Elton, has done a terrific job in recruiting authors for the newsletter. Members of the SIG also generated manuscripts for last year's special interest issue on Occupational Health Physical Therapy. The OHSIG welcomes contributions for the newsletter from any of our members. Topics can include anything of interest in the area of occupational health physical therapy. If you have ideas but want input prior to submission, feel free to contact Karen Elton (see contact information below) for advice or suggestions.

***Programming for CSM 2001 and 2002:*** Bonnie Sussman, our Vice President, presented an excellent preconference workshop on Office Ergonomics that was attended by over 65 people. Guy Simoneau, PT, PhD, ATC presented a terrific review of the literature on input devices (keyboards and mice) and provided insight into his own research in the area. He and his colleagues promise to remain leaders in this area of research. Eileen Vollovitz gave a thought-provoking presentation on both new and old concepts in office seating. Her novel approaches helped the attendees think *out of the box* with regards to seating. Thanks goes out to Bonnie Susssman, Vice President, and Dee Daley, our newly appointed Education Chair, for making our programming this year a tremendous success!

Next year we plan to address the areas of industrial ergonomics and the ergonomics of patient handling in our programming. We will be exploring joint programming with the Hand, Acute Care, and Geriatrics Sections. We are also hoping to provide another preconference course on the evidence surrounding the effectiveness of prevention. Remember, evidence-based information can help you market your services to business and industry, especially if you are new to the field and do not have your own track record.

***Practice Analysis:*** Those of you who attended our Business Meeting in 2001 will remember that you passed a motion charging the OHSIG BOD to apply to the Orthopaedic Section for a Practice Analysis Grant to further define the practice of Occupational Health Physical Therapy. Our plan is to use the information gathered in the practice analysis process to determine whether there is justification for a specialization or certification in Occupational Health PT. Ken Harwood, our Practice Committee Chair, did an excellent job of researching the process and putting together a comprehensive and detailed application. Unfortunately, due to the fiscal problems facing the Orthopaedic Section, they were unable to fund the grant. In addition, we found that our discretionary funds were unavailable for our use to begin the practice analysis process. After extensive discussions with the Orthopaedic Section BOD, we are setting in motion a plan for reinstating our funds as quickly as possible so that we can move ahead in 2002 with the practice analysis process. We are working together with all SIG Presidents to ensure that the needs of all SIGs are met in a timely and equitable fashion as soon as funds become available.

***O*NET:*** The Dictionary of Occupational Titles (DOT) is slated to be replaced with the newly developed O*NET. If you are not familiar with the O*NET, you may want to go the Department of Labor's web site and take a look. The O*NET will be a drastic change in the way the physical demands of work are classified. You may be thinking that such a change will not affect you very much since you seldom use the DOT. Instead you may rely on patient self-report or job demands analysis to determine the physical demands of

the job. However, O*NET may change the way you are required to analyze patient's functional abilities in an FCE and the variables you examine during job demands analysis. The classification system on which O*NET is developed is one that is geared toward self-report of the worker, not quantitative job demands analysis. If you are not familiar with O*NET, now is the time to educate yourself .

The Social Security Administration (SSA) has determined that O*NET will not be adequate for the purposes of their disability determinations and has requested that the Department of Labor (DOL) work together with them to determine how to further develop O*NET to meet their needs. The DOL and SSA have approached the International Association of Rehabilitation Professionals (IARPS) and asked them to participate in providing input regarding further refinements to O*NET. IARPS has approached its sister organizations—APTA, AOTA and others—to provide representatives to serve on an inter-agency task force within IARPS. The task force has met once with DOL and SSA in October 2001 for some preliminary, informal discussions. They are slated to meet again at the end of March 2002 to further those discussions. Many of you should expect to receive formal requests for input as they these agencies ask for advice on further O*NET development. As your representative from APTA, I will keep you informed through the newsletter as this process unfolds. If any of you have a particular interest in further information, please feel free to contact me.

***Bylaws Revisions:*** Many thanks to our Vice President, Bonnie Sussman, for revising our bylaws this year to be in compliance with the Orthopaedic Section bylaws.

***Providing testimony on ergonomics:*** OSHA ergonomic standards were repealed in February 2001. In July 2001, the Department of Labor sought guidance from stakeholders on the need for a national plan for work-related musculoskeletal disorders. The Practice Committee Chairperson, Ken Harwood, PT, PhD, CIE, submitted written testimony on behalf of the APTA recommending the need for a national plan and the importance of physical therapists in that plan. In addition, he presented oral and written testimony before the United States Senate Subcommittee on Employment Safety and Training of the Health, Education, Labor and Pensions Committee. Here he clarified the role of physical therapists in the evaluation and intervention of individuals with work-related musculoskeletal disorders.

***Input into the Guide to Physical Therapist Practice:*** Ken Harwood, PT, PhD, CIE Practice Committee Chair has worked with the APTA's Office of Practice to edit the tests and measures list in Occupational Health Physical Therapy for Phase III: Guide to Physical Therapist Practice.

***Research Retreat:*** Frank Fearon, PT, DHSc, Research Committee Chair developed a preliminary plan for a Research Retreat on the evidence supporting prevention interventions which we had hoped to host in the Fall of 2002. Unfortunately, budgetary constraints have prevented us from moving ahead with our plan. Given these fiscal constraints, we are considering another approach to the retreat concept. We are currently exploring the possibility of developing this programming for a preconference course for CSM 2003. This venue would allow us to move ahead with providing the information to members and promote discussion of prevention research and its implications for clinical practice.

***Home Study Course:*** A home study course on evidence-based practice in Occupational Health Physical Therapy was initiated in 2001 with plans for publication in 2002. Frank Fearon, Research Chair, is serving as content editor. Manuscripts are in progress but are temporarily on hold until budgetary issues are resolved with the Orthopaedic Section (ie, the OHSIG has a written policy from the Orthopaedic Section that addresses the handling of SIG monies earned through HSCs and Continuing Education Courses). We are confident that these issues can be resolved over the coming weeks and that work will resume on the Home Study Course in a timely fashion.

Despite the turbulent times, the OHSIG is moving ahead with its plans and initiatives. As President, on behalf of the Board of Directors, I invite you to become active participants in any way that you can. Join a committee, attend programming and our business meeting at CSM, write for the newsletter, purchase the upcoming home study course, and respond with input when you receive mailings on O*NET and/or the Practice Analysis. Join us in moving the practice of Occupational Health Physical Therapy to the next level! Last but not least, I would like to thank each member of the OHSIG BOD for his or her hard work and support!

**Functional Capacity Assessments – More Than Just a Tool for Assessing Injured Workers**

*Kim Stewart, OTR/L*

In April 1995, I underwent the certification process for administrating a standardized functional capacity evaluation. I was certified to perform the 'Ergoscience Physical Work Performance Evaluation.' For approximately 1 year I used this evaluation tool to perform FCEs for Workers Compensation, lawyers, Vocational Rehabilitation, Social Security Disability and local employers to determine an individual's physical ability to perform work and/or to determine at what level of work to which they were capable of returning. During this time of performing FCEs, one thing became very clear. I found that in the majority of FCEs that were performed, I was unable to accurately determine if an injured individual could safely return to their previous area of employment. The information obtained from the FCE was more than sufficient to determine the level of work the individual could perform; however, the ability to do the job match portion of the reporting was the area that was lacking. I determined the main problem, in completing this portion of the testing, was the lack of information in the position descriptions that were received from the various referral sources. The position descriptions that I received did not provide me with enough information as to the exact physical demands that were required of the individual to perform the essential functions of the job. The job title, along with job duties of *must be pleasant,* did nothing to tell me what this individual had to do in regards to the physical requirements

necessary to hold that particular job. In discussing this problem with the various referral sources, it was easy to see that a job analysis process needed to be developed to help determine the exact physical demands of a job to enhance the existing position description.

## JOB ANALYSIS

Several local employers jumped at this idea to not only obtain an accurate, detailed position description in accordance with the Americans With Disabilities Act (ADA), but also to enable me or other health care providers to determine if an individual does match the job for which they are employed.

Under the ADA, the position descriptions are considered evidence of the job. The essential functions are the basic job duties that the employee must be able to perform, with or without reasonable accommodations; they should determine both the intellectual as well as physical demands of the job. The employers that I worked with determined the essential functions of each job title within their company. It was my job to determine what was physically required of the employee to perform each essential function listed.

The first step in developing the job analysis process was to develop an assessment tool. I used my background in performing a functional capacity evaluation to develop the protocol for the job analysis and the reporting forms that I presently use. I knew what information was needed, so the next step was to obtain it. I started my adventure at the coal mines here in North Dakota. I received the existing position descriptions that were on file with the human resource departments and set out to become that employee to determine what was physically required to perform that job. I requested that I follow an employee that had been in that position for several years. I felt the experience was necessary to look at all aspects of the job. I did talk with the supervisors after the walk through with the employee and reviewed the information gathered during the job analysis. It was interesting to see the different perspectives as to what the physical demands of the job were as interpreted by the employee vs. the supervisor. They agreed on the physical demands of the job; however, there was discrepancy with the frequency level at which each task was performed. The following physical demands were evaluated for each job analysis:

Dynamic Strength – determine both the amount of weight lifted and the frequency
- Floor to waist
- Waist to eye level
- Bilateral carry
- Unilateral carry
- Pushing
- Pulling

Position Requirements – determine frequency level and specific task involved
- Sitting
- Standing
- Work arms overhead
- Work bent over/stooping
- Work kneeling
- Work bent over/sitting
- Work squatting
- Work with arms overhead/ supine
- Grasping
- Bent wrists

Mobility – determine frequency and specific task involved
- Climbing stairs
- Repetitive squatting
- Walking-uneven surfaces
- Walking-even surfaces
- Crawling
- Climbing a ladder
- Trunk rotation-standing
- Trunk rotation-sitting
- Balance
- Shoveling
- Vibration
- Alternating hand movements
- Equipment/tool handling
- Arm/elbow movements
- Head movements/rotation

If you are at all familiar with standardized functional capacity evaluations you know that the physical tasks that are evaluated during the job analysis are similar to the areas tested for in a FCE. The additional tasks were added at the request of the employer and/or specific physical requirements were mandated for certification purposes in various work areas.

## DETAILED JOB DESCRIPTIONS

Once all the positions were evaluated and the physical demand forms were completed they were sent to the companies for review by the human resources department, the employees, and the supervisors. Upon final approval by the company, the information became part of their official position description. The detailed position description is in compliance with the ADA and can be used by health care providers to accurately determine if an individual can safely return to their previous level of employment. The detailed position description also can help with providing information for companies to make reasonable accommodations for returning an individual with work restrictions back to productive employment. The specific physical capabilities of an individual can be determined by performing an FCE. Along with the detailed position description, an accurate job match can be determined.

A total of 6 larger employers in our service area have used the job analysis process to develop detailed position descriptions as described above. The physical capabilities determined by the FCE and the detailed position description providing accurate job match information proved to be very successful. It developed into a win-win situation for everyone. Benefits noted by these employers were:

- Earlier return to work for employees after an injury. The information obtained from the FCE helps with development of transitional work for employees that are able to return to work but with work restrictions and with matching the employee's physical abilities with job requirements.

- Decrease in the fear factor of the employee as they return to work. Demonstrates that an individual is capable of doing functional tasks of the job safely.
- Decrease in exacerbation of symptoms reported by the employee after returning to work. If you can demonstrate that the employee is physically capable of performing the essential functions of the job without an increase in symptoms, the likelihood of symptom magnification is decreased.
- Improved the confidence level of all involved knowing that the individual is physically capable of returning to productive employment.
- And most importantly, the direct and indirect cost savings for the employer. Keeping the employee on the job or earlier return to work leads to cost savings in all aspects from worker's compensation, to new or temporary employee training to fill the position.

## ADDITIONAL PROGRAM DEVELOPMENT

There was no question that the job analysis process developed was beneficial but there were other program areas that could be explored using the same knowledge base. Why couldn't the information, already at my hand, be used to accurately determine if a new hire matched the physical demands of the job? Why not! The process was then developed to offer preplacement screenings. The standardized FCE protocol continued to be used. The areas tested were job specific in accordance with the information provided on the detailed position description. This was an easy transition. The only difference was testing a healthy individual vs. an individual with a work-related injury. The preplacement screening process was established for all of our clients that were already involved in the FCE and job analysis programs. Preplacement evaluations were performed on new hires, summer help, employees transferring to new positions within a company, and temporary or intern positions. Again this is all in accordance with the ADA. In the 3 years that I have been performing preplacement screenings, matching the individual to the job, we have tracked no work-related injuries to any employees that have been evaluated. I feel this is an excellent track record.

There is still one area we are looking into developing and that is fit-for-duty testing. Companies interested are presently exploring the legal issues into requiring existing personnel to take a yearly physical evaluation to determine if they match the physical demands of the job. All these programs have one main purpose—to prevent work-related injuries. It is refreshing to be part of a proactive approach with unlimited potential for future program development. I find it exciting and rewarding to work with industry as they realize how important injury prevention is and ways they can intervene to create a safe work environment. I hope that this is not the end of the story but a new chapter for the future with endless possibilities.

*Kim Stewart, OTR/L holds a B.S. degree in Occupational Therapy and is currently employed at Medcenter One Health Systems in Bismark, North Dakota.*

## OHSIG Officer Listing

| | |
|---|---|
| PRESIDENT | **Deborah Lechner, PT, MS**<br>ErgoScience, Inc<br>15 Office Park Circle, Ste 214<br>Birmingham, AL 35223<br>Ph: 205 879-6447, ext. 204<br>Fx: 205 879-6397<br>Email: deborahlechner@ergoscience.com |
| VICE PRESIDENT | **Bonnie Sussman, PT, MEd**<br>Cioffredi & Associates Physical Therapy<br>PO Box 727<br>Lebanon, NH 03766<br>Ph: 603 643-7788<br>Fx: 603 643-0022<br>Email: bsussman@tpk.net |
| TREASURER | **Mark Blankespoor, PT**<br>1316 N Prairie St<br>Pella, IA 50219-1383<br>Ph: 641 621-0230<br>Fx: 641 621-0319<br>Email: worksystems@lisco.com |
| SECRETARY | **Karen J. Elton, PT, MA**<br>Therapeutic Associates of Central Oregon<br>2600 NE Neff Road, Ste B<br>Bend, OR 97701<br>Ph: 541-388-7738<br>Fx: 541-388-7785<br>Email: kelton@taiweb.com |
| PRACTICE & REIMBURSEMENT | **Kenneth J. Harwood, PhD, PT, CIE**<br>Columbia University<br>710 West 168th St, 8th Fl<br>New York, NY 10032<br>Ph: 212 305-1649<br>Fx: 212 305-4569<br>Email: kh111@columbia.edu |
| RESEARCH | **Frank Fearon, PT, DHSc, OCS, FAAOMPT**<br>North Georgia College & State University<br>Barnes Hall-Department of Physical Therapy<br>Dahlonega, GA 30597<br>Ph: 706 864-1899<br>Fx: 706 864-1493<br>Email: ffearon@ngcsu.edu |
| EDUCATION | **Deirdre Daley, PT, MSHOE**<br>ProActive WERC Center<br>1211 Ireleand Drive, Ste 11<br>Fayetteville, NC 28304<br>Ph: 910 678-8085<br>Fx: 910 678-8683<br>Email: kanandarqu@aol.com |
| NOMINATING | **Allen Wicken, PT, MS**<br>Wellness Program Director<br>Rangeley Region Physical Rehabilitation & Wellness Pavillion<br>PO Box 722<br>Rangeley, ME 04970-0722<br>Ph: 207 864-3332<br>Fx: 207 864-9062<br>Email: allenwicken@yahoo.com |
| MEMBERSHIP | **Scott Duesterhaus Minor, PT, PhD**<br>Washington University School of Medicine<br>4444 Forest Park Blvd., Box 8502, Room 1101<br>St. Louis, MO 63108<br>Ph: 314 286-1432<br>Fax: 314 286-1410<br>Email: minors@msnotes.wustl.edu |


**Performing Arts Special Interest Group • Orthopaedic Section, APTA**

## MESSAGE FROM THE PAST PRESIDENT

We had a great time at CSM this year. Our programming was very well attended, and we received a lot of wonderful feedback regarding the presentations. Many thanks to our presenters and to Lynn Medoff for putting together such an excellent program.

The practice analysis that the PASIG undertook at your direction last year is underway. We have completed and piloted a draft survey and hope to finalize the instrument so that we can send it out to membership in the next few months. We are on track to complete the survey and develop a Description of Specialized Practice for Physical Therapy for the Performing Arts by February 2003. So look for it in Tampa. We thank the Orthopaedic Section Board of Directors for their continued support and generosity.

The interstate practice issue is also being pursued. Many thanks to Joel Dixon who drafted an excellent motion and supporting statement to the Orthopaedic Section's Board of Directors. The Orthopaedic Section has sent an RC to the House of Delegates asking them to formulate a statement supporting interstate reciprocity. Stephen McDavitt, Practice Committee Chair, has worked very hard on behalf of this issue, and we appreciate it. We are taking the first steps towards interstate practice, but just as direct access has to be won state by state, so too will interstate practice.

As most of you know, your Executive Board had some turnover this year. I finished up my term as President, and Jeff Stenback completed his term as Treasurer. Your new president is Jeff Stenback, and your new Treasurer is Adrienne McAuley. I am extremely confident in your new President, and excited about the excellent Executive Committee that he has to work with. I am very thankful for the opportunity to serve the PASIG, and am indebted to many people for supporting my efforts. I look forward to continuing to participate in the PASIG, and helping with its maturation.

Thanks to everyone. We'll see you in Tampa.

*Jennifer M. Gamboa, MPT*
*Past President*

## MESSAGE FROM THE PRESIDENT

Greetings! I hope everyone enjoyed Boston and returned home safely. CSM 2002 was well attended and many things are happening. The PASIG Executive Board is happy to welcome Adrienne McAuley as our new Treasurer. In addition to her treasurer duties, Adrienne will be chairing the Public/Media Relations Committee. She will be happy to hear from any of you regarding upcoming performing arts-related courses, newsworthy items, or activities from our membership. If you would like to get a course announcement listed or have an idea for submission of an article, give her a call. Susan Guynes continues as our Secretary and will be taking over the Regional Directors Committee. She still has openings for members who would like to volunteer as Regional Directors in their region. Contact Susan for more information. Lynn Medoff, Vice President, did a fabulous job on our programming at CSM. It was a huge success and very well attended. Lynn is actively seeking ideas for CSM 2003, which will be held in Tampa, Florida.

We have several important upcoming issues. Our Practice Analysis is about halfway along and we have a completed survey draft that has already been piloted. As soon as we can secure the services of the firm who will be compiling the survey data for us, we'll be sending out the actual survey to each of you. The National Advisory Committee and especially the steering committee have worked quite hard to get us to this point. I know all of you realize that this very large undertaking can only be successful if each of us does our part by completing the survey and then, returning it promptly. We still are having difficulty contacting many of our members and it is extremely important that we have correct mailing address information on everyone. Please contact the Section office if a regional director did not already contact you—we DO NOT have your correct mailing address if you were not already contacted!

In addition, the PASIG has been approached by the Orthopaedic Section's *Orthopaedic Physical Therapy Practice (OP)* to do a special issue on "PT and the Performing Arts." The issue is due in June of this year and is a marvelous opportunity to showcase the PASIG and the diversity in our special interest group. Susan Appling, *OP* Editor, requested that we come up with 4 articles for this issue—we have 8! Many thanks to all of you who have so generously donated your time and expertise in agreeing to prepare submissions.

If you have ideas for an article, case study, research article or write-up of a clinical pearl, we are still accepting these and welcome your efforts—we would like to continue offering PASIG member goings-on as well as current information through *OP*. Adrienne McAuley will be actively seeking venues where we can also include performing arts-related physical therapy literature. Please contact her if you have ideas.

Lastly, but not least, the Executive Board decided at CSM that we would proceed with plans to offer a preconference course at CSM 2003, sponsored and prepared by our members. Plans and ideas for this preconference course are already underway and it promises to be a great way to kick off CSM 2003! This is an exciting opportunity to offer our expertise in movement analysis and will most likely focus on dance medicine. If you would like to help with the multitude of activities that will be required to make this course successful, please contact Lynn Medoff. Look for more details. We will keep you updated.

In closing, I do believe that it truly is a great time to be associated with the PASIG. Hopefully, you'll want to be involved too. More and more opportunities arise in our special interest area as time passes, and we are in an excellent position to stand as leaders in this area. We will be attempting to strengthen our ties with other groups that treat performing artists, such as PAMA and IADMS. Obviously, the PASIG is only as strong as our membership and we need and want to hear from each of you. I am genuinely proud of our group and want to express my thanks to you for permitting me to serve as your new President. I welcome your feedback and can be reached at JSPTOCS@aol.com or by phone (305) 595-9425.

*Sincerely,*
*Jeffrey T. Stenback, PT, OCS*
*President, Performing Arts Special Interest Group*

## 2001 PASIG BUSINESS MEETING MINUTES

Combined Sections Meeting
Boston, MA
February 22, 2002

**CALL TO ORDER and WELCOME** – 5:00 PM – Jennifer Gamboa, President

**MOTION:** To approve the minutes from the Business Meeting at CSM in San Antonio, Texas, on February 16, 2001, as printed in the Spring 2001 issue of *Orthopaedic Physical Therapy Practice.* **PASSED.**

**EXECUTIVE COMMITTEE REPORT:**

**A. Jennifer Gamboa, President:**

Applied for and received a grant for the Practice Analysis. The development of the survey instrument was completed and piloted and is ready to be sent to the PASIG membership and all other practitioners of Performing Arts Medicine. The PASIG is awaiting the money for the survey implementation and analysis and should be ready for presentation by CSM 2003. This practice analysis will be used to implement a specialist practice for Performing Arts Physical Therapists in the future.

The regional director position has been developed under the PR/Media Relations Committee, and was initiated to meet the PASIG objective of maintaining closer communication with PASIG members. Please remember if you have not been contacted, we need up to date information of your address/contact information.

**B. Jeff Stenback, Treasurer:**

Presented 2002 PASIG Budget. PASIG received $4350 from the Orthopaedic Section.

Special Recognitions:

- Amy Frank, PT Outgoing Nominating Chair
- Jeff Stenback PT OCS Outgoing Treasurer
- Special Recognition to the National Advisory Group on their help with the development of the Practice Analysis Survey
- Jennifer Gamboa, MS, PT, OCS Past Treasurer and Outgoing President

**NOMINATING COMMITTEE:**

Elections for President, Treasurer, and appointments for Nominating Committee members were held by the membership in the absence of nominating committee members. Terms are 3 years for President, Treasurer, and all committee chairs. Two years for one nominating committee member and 1 year for the other nominating committee member.

Election Results: 31 ballots returned with unanimous vote.

President: Jeff Stenback, PT, OCS
Treasurer: Adrienne McAuley, PT, OCS
Nominating Committee Chair:
Shaw Bronner, PT, MHS, OCS
Nominating Committee Members:
Julie O'Connell, PT and Amy Frank, PT
Public Relations/Media Committee Chair:
Adrienne McAuley, PT, OCS
Membership Committee: Susan C. Guynes, PT, MHS

**PRACTICE COMMITTEE:**

Marshall Hagins discussed the progress towards the Description of Specialized Practice (DSP) document, which will be developed from the Practice Analysis (see executive report). The committee also has developed an initial document of a universal screening tool for the performing artist. It will be sent out to the membership for feedback and adjustments. The goal is to get standardized forms available for screening of musicians and dancers.

Joel Dixon discussed the Interstate Practice issue for PTs who are working with touring groups and shows. He reported the Orthopaedic Section will present to the APTA House of Delegates a Position Statement to support the federation going state-to-state to get approval at the state level. This position also will impact sports medicine and other orthopaedic practitioners.

**EDUCATION COMMITTEE:**

Lynn Medoff reported on the programming (see below). She thanked the presenters for their case study and slide presentations. She also requested suggestions for future

programming from the membership and asked for feedback/suggestions on programming for CSM 2003. A few suggestions follow:

- MD/PT combination presentations were very well done and received.
- Consider joint programming with Orthopaedic or Sports Section.
- Consider using panel for presenting specific problems with musicians and dancers.
- Different programming to address both advanced and beginning level learners and allow for breaks.
- Preconference course for CSM 2003 with the support of the Orthopaedic Section.
- 2-4 hours of regular (non SIG) programming at CSM and at the Annual Conference.
- Consider developing a home study course especially designed for beginners.
- Begin compiling information concerning what it means to be a member of the PASIG.

**RESEARCH COMMITTEE:**

Reported they provided the speakers for the Case Study presentations at CSM with their ongoing dialog with the Education Committee. The group is currently involved with articles to be written and presented in the special issue on PT for Performing Artists for *OP* this spring. This committee is also charged with publishing a literature review on a quarterly basis including the development of a shared database on a central web site center.

**PUBLIC RELATIONS/MEDIA COMMITTEE:**

Jeff Stenback reported the committee is involved in getting out the logo and PASIG-related information through the Regional Directors. This subcommittee was developed to keep the membership up to date. One problem that arose this year was incorrect membership information. This subcommittee has been placed under the direction of the Membership Committee.

**MEMBERSHIP COMMITTEE:**

This committee is charged with the membership directory and is trying to compile current information for all PASIG members. The membership will be cross-referenced with the IADMS and a new welcome package will be developed for new members.

**OLD BUSINESS:**

The Orthopaedic Section has revised all SIG Bylaws to make them consistent with both Orthopaedic Section and APTA bylaws. The language and content of the Bylaws has not been substantively changed. Please contact the Executive Board for a copy of the recently updated bylaws.

**NEW BUSINESS:**

*OP* is offering a special issue with focus on the PASIG. The deadline is April 12th and 8 articles will be submitted for publication in this special format. Suggestions for vendors who might consider advertising in the special issue should be addressed to Jeff Stenback (see contact information below).

**MEETING ADJOURNED: 6:00 PM**

*Susan C. Guynes MHS, PT*
*Secretary*

**PASIG BUDGET 2001**

| *Activities* | *Expense* | *Budget* |
|---|---|---|
| A. General Expenses | | 1350 |
| Stationery/Supplies | 100 | |
| Telephone/Fax | 1000 | |
| Postage/Shipping | 200 | |
| Miscellaneous | 50 | |
| B. Travel Assistance for Executive Board | | |
| Line 4168 to attend CSM ($550/person X 4) | | 2200 |
| C. President or another Officer to Attend Fall Meeting | | |
| Ortho Section to fund | | (1055) |
| Line 4188 Travel | (470) | |
| Line 4189 Lodging/Meals (3 X $195) | (585) | |
| D. Reception at CSM 2001 (Will make other arrangements) | | 0 |
| Meeting Services | 0 | |
| E. Programming for CSM | | 250 |
| Line 4168 Travel – CSM | 0 | |
| Line 4169 Lodging/Meals – CSM | 0 | |
| Line 4176 Speaker Honorarium – CSM (2 speakers) | 250 | |
| F. Mailings to PASIG Membership | | 305**(205)** |
| Line 4115 Postage/Shipping | 230**(180)** | |
| Line 4116 Printing | 75**(25)** | |
| G. Membership Directory | | 375**(225)** |
| Line 4115 Postage/Shipping | 75**(25)** | |
| Line 4116 Printing | 300**(200)** | |
| H. Development/Maintenance Web Page | | 120 |
| Line 4120 Professional Fees | 120 | |
| I. Brochure/Welcome Packet Development | | 300**(0)** |
| Line 4116 Printing | 300**(0)** | |
| J. Membership Pins (Orthopaedic section has these) | | +50 |
| Line 3120 Sale of PASIG Pins ($5.00/ea.) (Estimate) | + 50 | |
| K. Nominations | | 100**(0)** |
| Line 4115 Postage/Shipping | 100**(0)** | |
| TOTAL | | $5000 |
| Revised Total | | $4350 |

*Jeff Stenback, PT, OCS*
*Outgoing Treasurer*

**CSM 2002 PASIG PROGRAMMING**

Attendance at this year's educational programming was excellent. The speakers were well received and appreciated by the audience. The program began with 2 physician/physical therapist teams. Michael Charness, MD and Regina Campbell, PT spoke on how they manage musicians with orthopaedic disorders. Lyle Micheli, MD teamed up with Heather Southwick, PT and Daniel Connors, PT in the discussion of dancers with anterior hip pain. The second half of the program consisted of a series of case studies. The first group of case studies, moderated by Linda Van Dillen, emphasized the technical aspects of writing case studies. The presenters—Laura McGuire, Jennifer Gamboa, and Tara Jo Manal—presented interesting case studies in the format discussed by Linda Van Dillen. The second group of case studies, moderated by Susan Guynes, addressed how to use the

*Guide to Physical Therapist Practice* when treating performing artists. Case studies were presented by Susan Guynes, Laura Schmitt, and Marshall Hagins. Thank you to all the speakers for their time and effort and willingness to share their expertise with the audience.

*Lynn Medoff, MA, MPT*
*Vice-President and Education Committee Chair*

## GET INVOLVED IN THE PASIG AND THE FUTURE IS YOURS!

Join your fellow PASIG members in becoming an ambassador for the Performing Arts! The PASIG wants to encourage all our members to become actively involved by serving as committee members, regional directors, officers, and by offering your input at business meetings and through communication with other PASIG members. Remember, when you give of your time and energy to the PASIG, it's like giving a gift to yourself! The PASIG is only as strong as its members. If you have an interest in committee involvement, please contact the Committee Chairperson, who is listed in the Directory on the last page of this newsletter.

## *PASIG Resources*

***Let PASIG help you MARKET your services!***

**PASIG BROCHURES AND LOGO PINS** are available to help you advertise and build your performing arts patient base. You can use the **BROCHURES** to market yourself to the performing arts community, the medical community, and to colleagues in the physical therapy community. You may proudly wear the **PASIG Logo Pin** to increase professional exposure.

The **PASIG MEMBERSHIP DIRECTORY** is an excellent resource for referrals, especially when your patients travel out of state. It includes state-by-state and alphabetical listing of PASIG members, as well as a Student Affiliation Site List. And don't forget, we still have **DANCE / MUSIC GLOSSARIES** available to assist you and your colleagues in communication with your performing artist patients. **ORDER NOW!**

| | |
|---|---|
| PASIG PINS | $5.00 |
| PASIG DIRECTORIES | $3.00 |
| PASIG BROCHURES | $15.00 (package of 25) |
| GLOSSARIES | $2.00 |

***TO ORDER:*** Call the Orthopaedic Section at 1-800-444-3982. **All proceeds benefit the PASIG.**

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*Members:* Julie O'Connell, PT; Amy Frank, PT

**Public/Media Relations Committee Chair:**
Jennifer (Adrienne) McAuley, PT, OCS
(contact information at left)

**Regional Directors**
**(Subcommittee of Membership Committee)**

- **Northeast** (CT, MA, ME, NH, NY, RI, VT)
  Marshall Hagins, Marijeanne Liderbach
- **Mid-Atlantic** (DE, DC, MD, NC, NJ, PA, VA, WV)
  Tara Jo Manal, Laura Schmitt
- **South** (AL, FL, GA, KY, LA, MS, SC, TN)
  Edie Shinde, Jeff Stenback
- **Central** (AR, IL, IN, IA, KS, MI, MN, MO, OH, OK, WI)
  Mark Erickson, Julie O'Connell
- **Northwest** (ID, MT, NB, ND, OR, SD, WA, WY)
  Cheryl Ambroza
- **West** (AK, AZ, CA, CO, HI, NV, NM, UT, TX)
  **Needs volunteers**

**Membership Committee Chair:**
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(contact information at left)

**Research Committee Chair:**
Lisa Sattler, PT
1140 First Ave. Apt. 6
New York, NY 10021-7961
Ph: 212.838.6847

*Members:* Scott Stackhouse

# Pain MANAGEMENT

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

## President's Message

*Joe Kleinkort, PT, MA, PhD, CIE*

"Life can be counted on to provide all the pain that any of us might need." Sheldon Kopp

Pain is a common denominator in our human existence. It is part of the very essence of life itself. Many if not all who read this have experienced short periods of pain but few have experienced chronicity. The devastation that it deals to mind, body, and soul is significant. It is that very issue of chronicity of pain that some of you have chosen to tackle. Many if not most of us feel so incomplete to address all the issues that arise in a patient's life with regard to chronic pain. The medical field, on a whole, is very poorly prepared to handle it in general. Certainly, physical therapists come out of school with less than adequate training in this arena. However, in many ways the physical therapist is blessed with the one thing that few other medical professionals have left, that is time with the patient. It is with the use of that time that we can be such a blessing. It is a time to *listen* and hear what the patient has gone through as well as give counsel as to how they are to physically and mentally work through recovery. The patient with pain needs the therapist to lean on and to coach in the rehabilitation progress. This may sometimes be done with *tough love*. Working through pain is so hard and so lonely! The hardest part is usually exercising through the pain. Few of us choose to hurt worse as we work through pain, but there is a fine line when working harder to regain our strength.

One of the major problems a patient with pain may encounter is the experience of *myopic self-absorption*. There is no greater waste of time that one goes through with pain than self-pity and self-preoccupation. As we try to cut ourselves from pain we also can be seen cutting ourselves from joy! True joy is one of the hardest things to mix with pain and yet it is one of the most complete and important feeling that we have.

"You and I were created for joy, and if we miss it, we miss the reason for our existence…if our joy is honest joy, it must somehow be congruous with human tragedy. This is a test of joy's integrity! Is it compatible with pain? Only the heart that hurts has the right to joy!" Lewis Smedes

It is joy that holds love and peace together and is very different from happiness. Joy is found in depth to the core of our being where happiness is superficial and fleeting. Joy is a choice! Failures and difficulties along the road to joy are part of the growing process that allows joy to stand on the firm concrete slab of trust that all has reason and there is nothing done in vain in our lives. Choose each day to have an attitude of **JOY** as you walk the difficult walk of life in pain and you will uncover an entire new dimension of life that you never knew existed.

"The longer I live, the more I realize the impact of attitude on life. Attitude, to me, is more important than facts. It is more important than the past, than education, than money, than circumstances, than failures, than successes, than what other people think or say or do. It is more important than giftedness, appearance, or skill. It will make or break a company…a church…a home. The remarkable thing is that we have a choice every day regarding the attitude we will embrace for that day. We cannot change our past…we cannot change the fact that people will act in a certain way. We cannot change the inevitable. The only thing that we can do is play on the one string we have, and that is attitude… I am convinced that life is 10% what happens to me and 90% how I react to it. And so it is with you…we are in charge of our Attitudes!" Charles Swindoll

## Sympathetic Therapy

*Joe Kleinkort, PT, MA, PhD, CIE*

Almost a year ago I reported about a new modality–sympathetic therapy system or STS–for those who suffered from chronic pain that seemed to show promise and I was able to report a few case histories.[1] In this issue Teena Petree, PT has graciously agreed to share a few more cases with some very unusual and beneficial side effects. Since my last report on this topic I have received numerous requests from around the country for more studies. There are two that have been written that I will try to summarize. Both of these show promising statistical results.

The first is by Dr. Ernesto Guido, MD, a neurologist, and is published in the *American Journal of Pain Management*.[2] Guido's study is on 20 patients suffering chronic pain caused by peripheral neuropathies. The subjects were treated for 28 days. At the onset of the study, 73% reported moderate to severe pain. By day 5 this number was reduced to 50%. By the end of the study, only one third of the subjects reported moderate to severe pain, and 50% of the subjects reported total relief of the pain. After the treatments were completed, 80% reported significant improvement in the quality of life, 80% reported sleeping better, and 40% were able to significantly reduce medications. The subjects had been previously unresponsive to numerous other treatments and medications. The increase in the quality and quantity is a tremendous side effect that seems to be effective even when pain relief is not complete or even partial. This in itself may be a significant benefit to the 44 million Americans who have sleep disorders.

The second paper is Retrospective Study of Sympathetic Therapy for Pain Attenuation in 197 patients (unpublished data). It is a retrospective study of a much larger group of 197 patients with

various chronic pain disorders. The author is a board certified physiatrist. Of the 197 patients, 33% reported complete reduction of pain and 58% reported mild to significant relief. Some experienced relief after the first treatment and some took 2 weeks to notice change. Eighty-three percent who achieved relief continued to experience it after 90 days. Eighty-five percent of the patients reported an increase in their activities of daily living of at least 50%. Seventy percent reported a reduction of at least 50% of their pain medications, while 77% reported an improvement in sleep by at least 50%.

This modality is by no means a panacea but an important new adjunct to the war on pain and its widespread effects on the quality of life. It is a very important tool for the clinician to use as they help to restore a patient's function. The ability to provide a patient with chronic pain additional quality sleep in itself is a critical factor in turning the tide. We eagerly look forward to further studies on this new and exciting modality for patients with chronic pain. This one modality is the most significant to come along in decades for the significant reduction of chronic pain.

**Case Studies–STS System**

*Teena Petree, PT*

Sympathetic Therapy System (STS, Dynatronics Corporation, salt Lake City, UT), a highly effective treatment for the symptomatic relief of chronic, intractable pain, is non-invasive, non-addictive and overall much more cost effective than most other treatments commonly prescribed to the chronic pain population. This patented method administers electrical current via peripheral nerves, which are accessed through the extremities, delivers a unique form of stimulation to the sympathetic nervous system. STS appears to *normalize* the sympathetic nervous system resulting in symptomatic relief of certain types of chronic intractable pain. This type of therapy seems to be most effective in the reduction of pain in patients with Complex Regional Pain Syndrome, better known as Reflex Sympathetic Dystrophy.

The following are 2 case histories of patients treated at Summit Physical Therapy in Dallas, Texas.

Sheila is a 44-year-old female with an 8-year history of interstitial cystitis and HNP L4-5. Abdominal and bladder spasms caused pain 8/10 with all functional ADLs. She experienced difficulty working as a teacher's aide. This patient had not responded to traditional treatment for these diagnoses including but not limited to oral medication and bladder injections with DMSO and hydrogen peroxide.

The patient received traditional PT treatment including visceral mobilization, joint mobilization, myofascial release, and electrical stimulation using interferential current, and a home exercise program of pelvic stabilization and stretching to diminish spasms and pain. This program, in addition to 75-100 mg of Ultram per day, allowed her to perform ADLs for limited periods of time.

Initially her status was 4-5/10 rolling in bed and rolling to sit. She could stand or walk 30 minutes with pain increase to 8/10 and drive with pain increase to 7/10. Frequency of urination was once an hour with medication and twice per hour without.

Sheila began STS treatment on 10/25/01 and received 10 treatments. After the 4th treatment, she noticed a decrease in bladder pain and urgency and was able to lower her Ultram to once a day. At the conclusion of 10 treatments, she was pain free and was able to resume ADLs with no urgency to void for 2 hours for the first time in 8 years. She remained pain free with no medications for 1 week after which her symptoms began to gradually return. She is currently waiting for a home unit so that she can treat herself once a day.

Lisa is a 37-year-old female with complaints of left lumbosacral pain, left hip pain, tingling or numbness into the left lower extremity, and drop foot. She underwent a lumbosacral discectomy in September of 1999. In June 2000 the patient tripped due to the drop foot injuring her right sacral wing and left symphysis pubis. The patient was diagnosed with pseudo gastroparesis because of a viral infection and was no longer able to eat or drink. Gastric tubes were inserted into her lower intestines to avoid starvation. She would often experience spasms in her lower intestines while trying to administer the liquid feedings. Asthma-like symptoms resulted in thoracic spine instability and muscle spasms for which she was on high doses of steroids and multiple medications for pain control.

The patient began STS treatment on 8/13/01 and received 10 treatments. During the treatments her lumbosacral pain decreased from 6/10 to 3/10, right sacral pain decreased from 8/10 to 4/10, and her left lower extremity pain decreased from 5/10 to 0/10. Drop foot was abolished and she no longer needed her ankle support after 2 visits. On the third visit, her stomach mobility returned somewhat and she was able to drink water and/or nutritious drinks; the muscle spasms in her lower extremities ceased. She was able to pump in a day's supply of food in 1 hour.

She was able to stop pain medications and decrease her steroid medications by 80%. As spasms in her intestines were abolished, her breathing normalized. She was able to ride a bicycle for 20 minutes a day and walk for 20 to 30 minutes. She remained unable to lift and carry more than 10 to 15 pounds. The patient did receive a home unit and she has continued daily treatment. All of her symptoms are diminishing.

**REFERENCES**


1. Kleinkort J. Too good to be true. Autonomic modulation: Fact or fiction. *Ortho Phys Ther Practice.* 2001;13(1):37-38.
2. Guido E. Effects of sympathetic therapy on chronic pain in peripheral neuropathy subjects. *J Am Pain Manage Assoc.* 2002;12:31.


## PAIN MANAGEMENT SPECIAL INTEREST GROUP BOARD LISTING

# Animal Physical Therapist

## SPECIAL INTEREST GROUP

## Orthopaedic Section, APTA, Inc.

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Joe Godges, DPT, MA, OCS

**SIG Coordinator and Off-Site Continuing Education Coordinator**
Stefanie Snyder

### CALENDAR OF EVENTS

The home study course **Basic Science for Animal Physical Therapists** is still available. Contact 877-766-3452 for more information.

### THE ANIMAL PHYSICAL THERAPIST SPECIAL INTEREST GROUP (ANIMAL SIG) UPDATE

1. Orthopaedic Section Member and nonmember directories are available through the Section Office 800-444-3982, Fax: 608-788-3965, or Email: ssnyder@century-tel.net. There are currently 544 members.
2. State Liaisons: To date there are 33 states that have Animal SIG Liaisons. Contact Siri Hamilton for further information 865-974-2993 and E-mail: sirivtpt@utk.edu.
3. The APTA has a web site that lists all of the State Practice Acts: www.apta.org/advocacy/state/state-practice

**President's CSM 2002 Report**

The Animal SIG has addressed the following goals within the Orthopaedic Section.

*GOAL #2*

Create dynamic leadership development programs for Orthopaedic Section members.

OBJECTIVES

4. Provide new and innovative ways to foster involvement of "grass roots" membership including members of diversity and affiliate members with the intention of mentoring them for future leadership roles.

   The Animal Physical Therapist SIG held a retreat February 19-20, 2002 in Boston. Among the discussion items for the retreat were consideration of the recommendation to the Orthopaedic Section that the SIG broaden its perspective to address the needs of all PTs and PTAs working with animals. This would involve inclusion within the SIG of the following areas:

   The current perspective of prevention and intervention of animal injuries, the addition of prevention and intervention of injuries/pathology of assistance animals, prevention and intervention of overuse and other injuries/pathology of owners of animals with injuries/ pathology, and owners of assistance animals intervention for people for whom an assistance animal is used.

   Another discussion item for the retreat was the organization of a welcome packet for new members and inquirers. This packet to date has included a general statement and the collective answers to "Frequently Asked Questions" as published in the Newsletter for the *Orthopaedic Physical Therapy Practice* publication. This packet could be accessible on the Section website.

STRATEGIES

c. Attempt to include one "inexperienced" member on each committee.

   Committee members and officers have involved collabo-

ration of interested people, mostly those living in their geographic areas. Nominations this year involve a new Nominations Committee Chair, Debbie Gross, and a new member of the Nominating Committee, Lynn Whelan.

d. Create an interactive bulletin board between members and officers, committee chairs, and SIG presidents for international discussion opportunities.
   An interactive bulletin board/listserv has been discussed as a useful information sharing mechanism. The SIG has made a motion that the Orthopaedic Section investigate the idea of an interactive bulletin board/listserv for Section/SIG use. This service could help meet the goals of providing ways to foster involvement of "grass roots" membership, assisting collaboration of people to develop educational materials, assist international collaborations in a cost effective way, and providing ways of sharing interventions. The cost of this service could be shared by any of the components of the Section / SIGs who want to participate.

**GOAL #8**

Maintain current membership growth rate of 2%.

**OBJECTIVES**

3. Support continued growth and development of current SIGs.
   See the item under Goal #2 Objective 4 regarding consideration of the recommendation to the Orthopaedic Section that all PTs and PTAs working with animals be incorporated into the SIG and the item regarding the Welcome Packet. These two items would support SIG growth as well as Orthopaedic Section growth and information sharing within the SIG, respectively.

**STRATEGIES**

a. Develop an orientation plan for SIG leadership, including training by the Orthopaedic Section Board and internal SIG training
   Duties and Responsibilities for Animal PT SIG officers and committee chairs have been developed and submitted to the Orthopaedic Section.

d. Document the history of each SIG and archive the history at the Section office.
   There has been no progress on this item.

e. Develop a brochure describing each SIG.
   The development of a brochure was discussed at the retreat.

f. Develop educational materials.
   Development of educational materials has occurred in two areas.
   Animal anatomy was documented as the area in most need of development for SIG members. The equine and canine anatomy and biomechanics home studies have been developed and are in use. Currently, Cassand Crispo is developing a similar series on cats.
   Another area in need of development is the scope of practice for animal rehabilitation. The SIG submitted a practice analysis grant to the Orthopaedic Section for this purpose, however, no grants were awarded this year. The SIG will discuss possible ways to move forward on collecting this information.

g. Investigate establishing international collaborative efforts and pursue if consistent with the mission statement of the SIG.
   This effort is continuing. The 2nd International Symposium in Rehabilitation and Physical Therapy in Veterinary Medicine will take place in Knoxville, TN August 10-14, 2002. At this meeting, there will be a discussion about the formation of a new International Association in Veterinary Rehabilitation/ Physical Therapy.
   Six nations who have formally established animal rehabilitation groups as recognized by their parent organizations are needed in order to for a WCPT group. Presently 5 nations, the UK, Netherlands, the US, South Africa, and Finland have formally established groups.

h. Investigate translation of relevant SIG educational material into other languages as consistent with the mission statement of the SIG.
   There has been no progress on this item.

Other progress within the SIG:

**Establishment of an APTA-AVMA Liaison**

Despite the efforts of Ben Massey, President of the APTA, the (American Veterinary Medical Association (AVMA) has not approved the establishment of a formal liaison between the AVMA and the APTA. Efforts will continue in this area, with the encouragement of veterinarians to approach the AVMA with the request for this liaison.

**Credentialing Process**

The University of Tennessee has established a certification process for canine rehabilitation. There is ongoing discussion regarding the knowledge and skill based materials that are presented to physical therapists, physical therapist assistants, veterinarians, and veterinary assistants.

**Practice Issues**

Progress has been made in many practice areas and for many animals. The most advances have been made with rehabilitation protocols, functional outcomes, and outcome studies for dogs and horses.

**Education**

Numerous presentations have been given in the past year by SIG members and others. Veterinarians began attending the CSM presentations in 2001. Several presentations were made at veterinary conferences, both through submission of abstracts and by invitation.

**Activities by the President**

- for the Newsletter in the *Orthopaedic Physical Therapy Practice* publication: solicited articles, edited each issue;
- responded to numerous communications regarding interest in animal rehabilitation;
- agreed to be interviewed for an article for the *Advance*;
- had contact with Ben Massey and members of the

Orthopaedic Section Board regarding legal issues involving animal rehabilitation, including: establishment of an APTA-AVMA liaison, legality of practice issues;

- collaborated with Becky Newton, David Levine and Carrie Adamson on preparation of the Practice Analysis Grant and submitted the grant to the Orthopaedic Section;
- submitted requested reports;
- organized the February 2002 retreat;
- presented at the American College of Veterinary Internal Medicine Conference in Denver, CO 2001;
- collaborated with Carrie Adamson, MS, PT and Chair of Practice for the SIG, to hold meetings every 1-2 months in the Denver area for physical therapists interested in animal rehabilitation;
- consulted with clinicians on research projects related to animal rehabilitation;
- promoted use of the Canine and Equine Anatomy and Biomechanics home studies by purchasing the right to offer the home studies to students of the University of Colorado Health Sciences Center Physical Therapy Program;
- consulted with Cassand Crispo, who is writing a companion series of home studies for cats;
- assisted in arranging a clinical affiliation in animal rehabilitation for one physical therapy student at Regis University, Denver, CO;
- assisted in arranging the option for a clinical affiliation in animal rehabilitation for physical therapy students at the University of Colorado Health Sciences Center, Denver, CO; and
- assisted area physical therapy graduates and clinicians in seeking opportunities to practice in collaboration with veterinarians.

*Submitted by,*
*Cheryl Riegger-Krugh ScD, PT, President*

## MISTY: A CASE STUDY

*Siri Hamilton PT, LVMT*

### HISTORY

On 2/25/01, Misty who is a 7-year-old Australian Shepherd Dog ran head on into the edge of a storm door. This incident occurred while the owners were on vacation at the beach. The owners recounted that immediately after the impact she went down and had a *seizure like episode*. She became unable to right herself and barely able to lift her head. She was immediately taken for emergency veterinary medical care at the local emergency clinic. Emergency care included but was not limited to, Valium, steroids, and diagnostics.

Diagnostics included a CT scan that was within normal limits, a myelogram showing no signs of spinal cord compression, and skull radiographs, inconclusive for fractures.

Misty was diagnosed with fibrocartilaginous embolism (FCE). FCE is a spinal cord infarction, which results from an embolus of material identical to the nucleus pulposus of the intervertebral disk, causing an ischemic episode to the spinal cord.

Before this injury, the owner's reported that Misty was in good health with no significant previous medical history

Rehabilitation began 3 days postinjury at a specialty referral hospital that offers rehabilitation services. The owners reported that initial rehabilitation consisted of assisted swimming in a pool and some type of electrical stimulation for a total of 13 visits. When Misty was cleared for travel, the family returned home to Knoxville, TN. Misty was admitted to the University of Tennessee College of Veterinary Medicine (UTCVM) for rehabilitation consultation.

### ASSESSMENT

Seventeen days after the injury, Misty presented with tetraparesis; (+) deep pain in all limbs; conscious proprioception absent in all limbs; forelimbs affected greater than rear, left side greater than right. The owners report that Misty was voiding infrequently and would eliminate both urine and feces in the house without any indication. After evaluation by a veterinary neurologist, the diagnosis of traumatically induced FCE was confirmed.

### PROGNOSIS

Potential for complete return to function was perceived to be fair to good. Misty was a good candidate for rehabilitation with the long-term goal of independent functional mobility.

### PROBLEM LIST

1. Nonweight bearing, all 4 limbs, and unable to sit in a sternal position.
2. Patient at risk for loss of muscle strength, and atrophy from disuse.
3. Patient at risk for adaptive shortening of soft tissue structures in limbs.
4. Patient at risk for decreased cardiorespiratory endurance.
5. Patient at risk for developing pressure sores.
6. Unable to posture independently to urinate, and defecate: at risk of developing urinary tract infection.
7. Owners in need of education for home exercises, functional care, and proper body mechanics for handling the weight of a down animal.
8. Patient becomes agitated with too much handling and will bite.

### REHABILITATION PLAN (To address problem list)

1. Instruct owners in passive range of motion and stretching techniques to maintain tissue elasticity, range of motion, and awareness of movement in preparation for return to weight bearing activities.
2. Frequent position changes. Padded and absorptive bedding to prevent maceration and resulting breakdown of tissues.
3. Begin assisted standing activities using slings and manual assistance.
4. Instruct owners in proper body mechanics.

5. All exercise and activity to be performed at a frequency and duration to meet the animal's tolerance, starting with frequent, short bouts of activity, progressing the time and frequency as tolerated.
6. Encourage normal bowel and bladder habits by taking patient outside frequently and regularly. Use of verbal cues and manual assistance for eliminating and posturing (calling on housebreaking techniques, which were used when Misty was a puppy).
7. Use of tetraparetic canine cart to assist with standing, gait training and functional independence.
8. Use of forelimb splint to prevent knuckling in left fore during stance and at rest to prevent further shortening of forelimb flexor tendons when nonweightbearing.
9. Begin manually assisted standing, gait, and cardiorespiratory activity in underwater treadmill (UWTM). Begin water activity with use of canine floatation vest. Progress to independent gait in UWTM, increasing time and speed as tolerated.
10. When able, progress Misty from assisted to active exercises to challenge balance, coordination, conscious proprioception, and strength.
    - Weight shifting in stance
    - Physio ball/roll activities
    - Cavaletti's
    - Balance board
    - Gait training on land treadmill and stairs (ascend/descend)
1. Home exercise program to parallel progress achieved. Update program as needed to continually challenge patient.
2. Discharge when Misty is able to safely and independently ambulate on level ground and up/down stairs independently.
3. Home therapy to continue with a goal of returning to prior level of function.

## OUTCOME

After 21 outpatient visits in 8 weeks time and daily home exercise, Misty was discharged from rehabilitation.

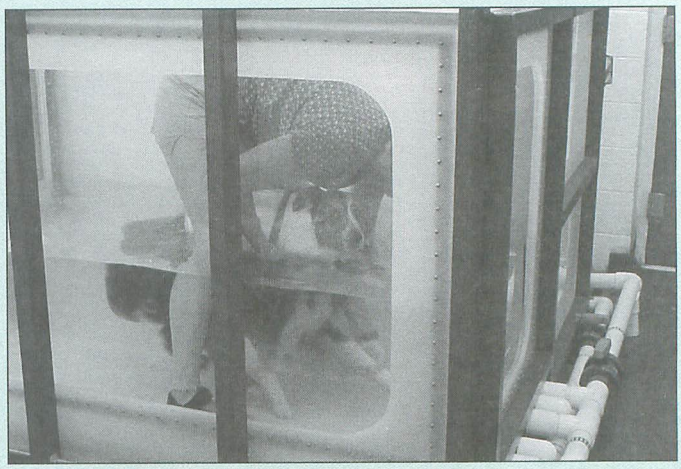
At time of discharge, she was independent with transfers (recumbent to standing), ambulating at the walk with mild ataxia (on level surfaces with traction), and able to trot with moderate ataxia. She required minimal assistance (<50%) to ascend stairs and moderate (50-75%) to maximal (75-100%) assistance to descend (using a sling or towel). She had regained normal bowel and bladder function. Her endurance and tolerance for active exercise had markedly improved in regards to time and intensity.

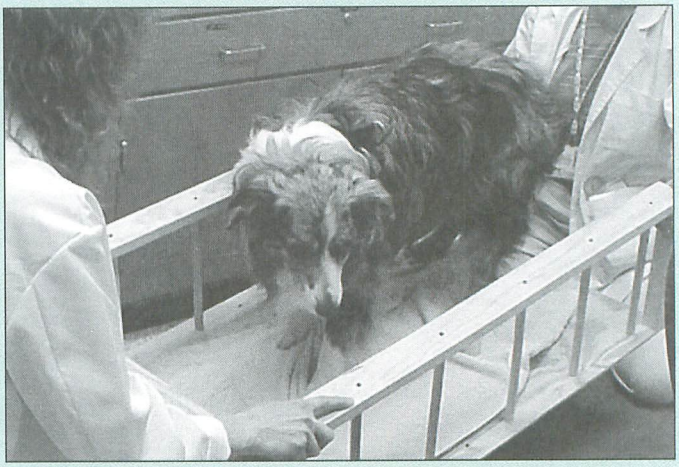
Misty made consistent, gradual progress during treatment. It appears she will regain full function in time. Physical rehabilitation has expedited her recovery of function, minimized potential complications, and given the owners an opportunity to be actively involved in this process.

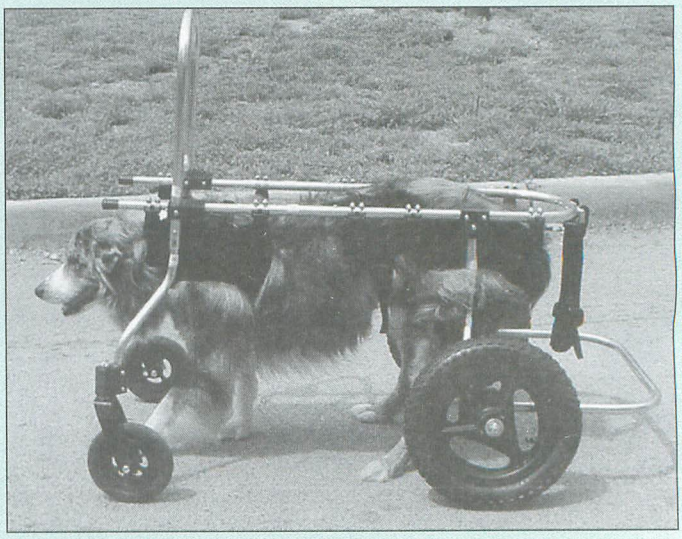
Addendum: Misty continued her rehabilitation with her owners back at the beach on Hilton Head, where she now runs into the surf during long daily beach walks.

Without a doubt, she has been one of the most rewarding cases yet. Physical therapists can really make a difference with animals too!

*Siri Hamilton PT, LVMT, University of Tennessee, College of Veterinary Medicine, Small Animal Clinical Sciences*







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# Instructions to Authors


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**Sharon L. Klinski, Managing Editor**
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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. Language and format of articles should be consistent with the *Guide to Physical Therapist Practice.*

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. Manuscripts are accepted by mail or electronically. If by mail, two copies of the manuscripts should be submitted along with a 3.5" disk with the document saved as Microsoft word or ascii. They should be double-spaced, with one-inch margins on each side. Four double-spaced pages equals one page in print. 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. If submitted electronically, please e-mail to Sharon Klinski, Managing Editor (sklinski@centurytel.net) and Susan Appling, Editor (sappling@utmem.edu), as well as mailing a hard copy to the Section office.

4. Black and white photographs to accompany the texts should be glossy 5 x 7. A photo release form must accompany any photographs where patients may be seen. Digital photos are also acceptable. Any tables that might add to the usefulness of the article are also welcome.

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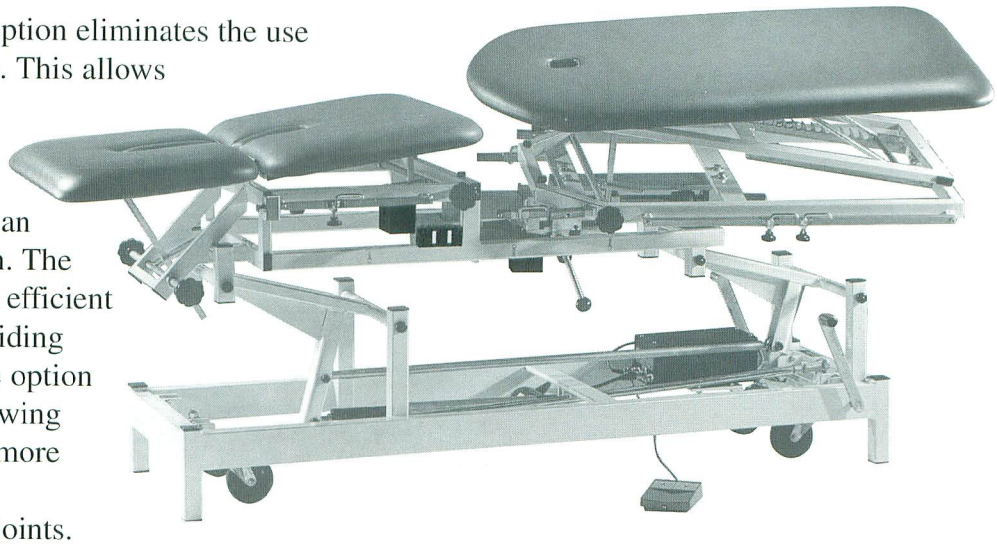

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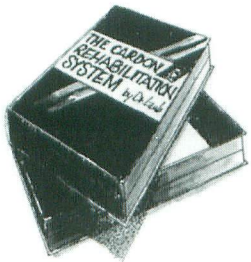


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