ORTHOPAEDIC PHYSICAL THERAPY PRACTICE

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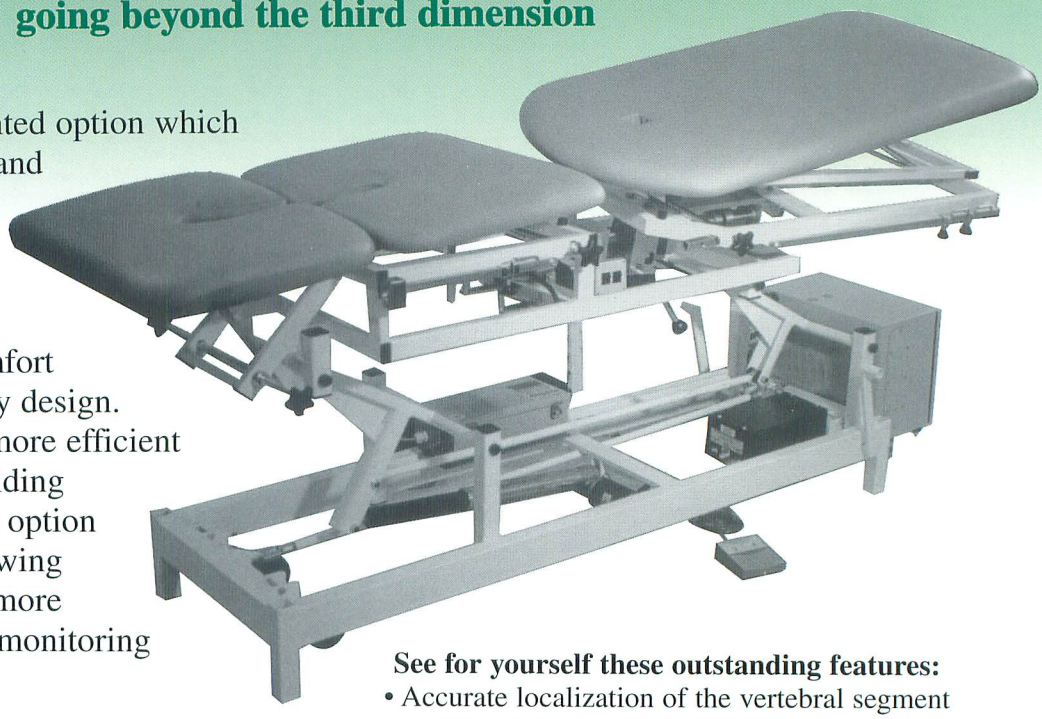

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TABLE OF CONTENTS

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The mission of the Orthopedic 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 quality patient/client care and promoting professional growth through:

- enhancement of clinical practice,
- advancement of education, and
- facilitation of quality research.

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Editor's Message

Happy Birthday!

Happy Birthday! This year marks the 30th anniversary of the Orthopaedic Section's founding in 1974. I suppose Happy Anniversary might be a better greeting, but as I write this editorial, it is nearing the holidays and I keep thinking about the greeting that Frosty the Snowman gives every time he is brought to life by the magician's magic hat. Happy Birthday! Either way, we are celebrating the Section's 30th year with a special issue of *Orthopaedic Physical Therapy Practice* (*OP*).

This special issue of *OP* is focused on the history of the Section. In addition to reprints of articles printed throughout the year of our 25th anniversary, there are new articles as well. Mike Cibulka and Bill Boissonnault provide us with the highlights of the Section's accomplishments over the last 5 years. Rick Ritter, with Jean Bryan, present us with a history of the Orthopaedic Clinical Specialist process. Mary Ann Wilmarth has written a tribute to the late Steve Rose, for whom the Section's Rose Excellence in Research Award is named. As usual, the SIG newsletters are included, with some of the SIGs providing us with history of their formation and development.

Thank you to all the authors of the articles in this issue. Your efforts are most appreciated. I would especially like to thank the Orthopaedic Section's staff for all of their hard work on this issue of *OP*, providing dates and details as we put the issue together. They are the ones who keep up with the details and track our movements. Our staff is a remarkable group of women. Members of the staff include Terri DeFlorian, Tara Fredrickson, Sharon Klinski, Linda Calkins, Kathy Olson, and Jessica Hemenway. Thank you all for the work you do for the membership of the Section everyday. You are a terrific bunch!

This issue of *OP* also marks the end of my term as Editor. After CSM, Chris Hughes, PT, PhD, OCS will take the helm as Editor of *OP*. I would like to take this opportunity to thank a few people who have made the last 6 years most enjoyable. My first thank you is to Sharon Klinski, Managing Editor of *OP*. Without Sharon's help and guidance, I could never have done this job and kept my sanity. In addition to being Editor for the past 6 years, I have also completed my course work and become a PhD candidate, as well as become a mother. Sharon understood my fast-talking edits, my crazy schedules, and my delays. She gently reminded me as needed, and always made sure the finished product was what we wanted it to be. During this time, *OP* grew in size and became a magazine. We began publishing one special issue each year, focusing on a particular topic or area of clinical interest. Also, *OP* is now indexed in CINAHL. In addition, we have remarkably increased our advertising income, thanks to Sharon and Linda Calkins, which has helped to offset the cost of production. Thank you Sharon for all that you do for the Section, and for all that you have done for me over the past 6 years.

Next, I would like to thank Bill Boissonnault. During his second term as President of the Section, Bill appointed me Editor. I was very hesitant to take the position, as I had just begun my doctoral program and didn't think I would be able to do the job. Bill encouraged me to take the position and I'm ever so glad for his encouragement and support, as well as the support of the Section's Board. Thank you to Jonathan Cooperman for his assistance in the transition as he completed his tenure and I began mine. I should also thank Nancy White and Lola Rosenbaum for inviting me to join the Education/Program committee in 1993, as this is what got me involved with the Section in the beginning. Thank you to Mike Cibulka for reappointing me to a second term as Editor. Lastly, I would like to extend my gratitude to all of the contributors to *OP* over the past 6 years. Without you, *OP* would be just a bunch of reports. You are the ones who make this magazine worth reading.

Now to reflect a little....Someone asked me when I first became Editor what my agenda was for *OP*. My answer was that I didn't have an agenda. I just wanted *OP* to continue to evolve and improve. Looking back, it appears that I did indeed have an agenda. The agenda most apparent to me was that *OP* be a publication where any and every member could contribute, be it through a clinical article or commentary, letters to the Editor, pilot research reports, or Section business. I wanted *OP* to be a place where both seasoned and new writers could publish their work. It is not a refereed journal. We have *JOSPT*, an excellent publication, for that. *Orthopaedic Physical Therapy Practice* is a magazine in which PTs and PTAs can share ideas, strategies, and comments. It is a place where any member can contribute. We wanted to increase the clinical usefulness of the magazine and, based on the comments we received from our recent on-line survey, we have accomplished that goal.

The second agenda item that became apparent to me upon review of my editorials is that of advocacy for the profession and involvement in the organization. I have written much about personal responsibility for the profession and the organization. Hopefully, at least one reader has been stirred to action on some level, be it in the clinical, governance, or legislative arena. I believe physical therapists and physical therapist assistants have great gifts that we should share, not only with our patients/clients, but with each other—as well as legislators, payors, community organizations, etc.

Well, I started this editorial with reference to a cartoon character, so I'll finish with a similar reference. Dr. Suess' "The Cat in the Hat" is now out in theatres, so I will end my piece with that frame of reference. I have written a short poem to express my feelings about coming to the end of my tenure as Editor.

Thank you. Thank you. Thank you ever so much.

I've gotten to work with a marvelous bunch.

The staffers, the writers, the membership too;

The committee chairs, Board members, and Presidents. Whew!

I learned I was orange and blue and a bit green.

No gold! Oh, that can make for a messy scene.

Lucky for me that Sharon has gold,

She balances our profile and makes sure *OP* fits the mold.

I am very proud of what *OP* has become,

Although Jonathan left me with quite a good plum.

Now then, in February, Chris Hughes takes the reins.

He'll make *OP* greater, just like big great Danes.

Again thank you for allowing me to be Editor for a while.

I leave you all now with a very big smile.

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

History of the Orthopaedic Section: The 1970s

Stanley V. Paris, PT, PhD
Dorothy Santi, PT

Reprinted from *Orthop Phys Ther Practice*. 1999;11(1):7-8.

The Section's History Committee has planned a 4-part series of articles depicting the key events in our founding, growth, and progression. The articles, authored by Stanley Paris, PT, PhD; Dorothy Santi, PT; Carolyn Wadsworth, PT, MS, CHT, OCS; Nancy White, PT, MS, OCS; and Joe Farrell, PT, MS appeared in 1999 and are being reprinted here.

The articles represent our attempt to initiate a written history, not only to record important events, but to rekindle the memories of long-time members about the best amount of energy and work that went into organizing the Section some 25 years ago. We also hope the articles will give our newer members an appreciation of the Section's evolution so that they will continue to work to ensure that our organization remains committed to promoting clinical research, quality education, and excellence in patient care. Both the Section's Board of Directors and History Committee sincerely hope that you enjoy the articles.

Joe Farrell, PT, MS
Director, Orthopaedic Section
Board Liaison, History Committee

In 1967, physical therapist Stanley Paris approached Eugene Michaels, then the President of APTA, about the feasibility of establishing a section for American Physical Therapy Association (APTA) members whose primary interest was manual and manipulative therapy. Paris was laboring under a 2-pronged disadvantage: First, President Michaels was not receptive because he feared that such a section would be too specialized and that if such a section were allowed, therapists in other areas of specialization such as ultrasound might too request their own section. Michaels clearly wished to avoid fragmentation of the national organization into a disparate collection of sections. Second, and perhaps more importantly, at that time manipulative therapy was not widely accepted within the physical therapy profession.

But Paris would not be dissuaded. That same year, 1967, a group of physicians—Dr. John Mennell and Dr. Janet Travel among them—formed the North American Academy of Manipulation Medicine. Paris wrote to the Academy requesting full membership for physical therapists, but Travel, the group's first president, replied that "manipulation [was] a diagnostic and therapeutic tool to be reserved for physicians only." Another brick wall.

Paris again persisted. He set about forming the North American Academy on Manipulation Therapy, with a formation meeting held in Boston on 28 August 1968. In attendance were invited representative of both the APTA and the Canadian Physiotherapy Association (CPA). Also present were Mennell from the United States and Cliff Fowler and John Oldham from Canada.

Interest in manipulation therapy was growing. In 1971, Paris and Oldham invited Freddy Kaltenborn to the United States and to Canada. Now, in addition to courses being taught by Paris, enthusiastic therapists interested in expanding their manipulation skills and knowledge base could participate in courses offered by Kaltenborn. The North American Academy on Manipulation Therapy presented a series of seminars, and physical therapists were eager participants.

By 1974, the Academy could boast of 942 members, mostly American. It met the growing needs of its members by publishing a newsletter and by conducting seminars and conferences. Even in the face of the Academy's success, many physical therapists held to the lingering sentiment that manipulation treatment was merely a fad. Academy leadership, however, saw that the Academy's goals could be met by forming an orthopaedic section within the APTA and a special interest group within the CPA. The foundation having been laid over the course of 7 productive years, the time had come for organization-building within the mainstream professional bodies.

In early 1974 a constitutional conference was called in Chicago, at which time bylaws were approved and officers elected. In June 1974, over 7 years after Stanley Paris first approached the APTA to request section status, the Orthopaedic Section was approved and Paris was elected its first President. Sandy Burkhart was elected Vice President; Peter Edgelow, Secretary; and Stan Schlacter, Treasurer. Also in 1974, Mariano Rocobado appeared on the scene. Rocobado's contributions, in conjunction with the continued activities of Freddy Kaltenborn, served to further advance the breadth and depth of manual therapy.

Dr. John Mennell, a strong proponent of physical therapists employing manipulation techniques, was the featured speaker at the inaugural banquet in June 1975. The topics of several position papers presented at that meeting presaged vital questions and controversies that the Section would face in the years to come: certification for specialization, chiropractic, and osteopathy. Coming challenges aside, 1975 marked the year in which our national body recognized mobilization as a valid treatment procedure, with the first APTA-sponsored course in joint mobilization preceding the meeting. At the meeting, plans also were made for the first Combined Sections Meeting to be held in Washington, D.C., in February 1976.

Orthopaedic Section leadership quickly recognized that its mandate extended beyond manual and manipulative therapy, and they began to address other issues in Section publications. Paris briefly served as the first editor of the *Bulletin*, succeeded by James Gould in the summer of 1976.

Threats to the physical therapist's right to practice joint mobilization were met head-on in 1976. Members voted to establish a legal fund to defend that right, the money to be raised by assessing $2 in addition to the $10 membership dues. This action was necessitated by challenges posed by the two groups. First, chiropractors voiced their opposition to physical therapists practicing manipulation. Chiropractors were becoming better organized and they were upgrading their curriculum by adding courses similar to those being taught in the typical physical therapy program. Second, athletic trainers in Pennsylvania substituted "athletic trainer" for "physical therapist" in their practice act and added, "to treat without physician referral." This was defeated. The APTA House of Delegates approved treatment without physician

referral in 1974 but rescinded it in 1978. These events, plus the fact the physical therapists could no longer practice chest physical therapy without sitting for the inhalation therapist examination, rendered the need to develop certification for specialization more urgent than ever. Further, the membership felt that an exam or a certificate of competency for teachers, too, should be developed. Recalling the 7 years it took to become recognized by the APTA as a Section, members realized that the immediacy of the problem demanded that the push for certification come from within the Sections.

The Task Force on Clinical Specialization held its first meeting in Washington, D.C., with representatives from all Sections plus 2 members-at-large in attendance. The Task Force worked out a tentative plan for Advanced Clinical Competencies to be presented to the 1978 House of Delegates. At the 1978 meeting of the House of Delegates, the concept of specialization was approved, and 1978 saw significant progress toward establishing competencies for specialization in orthopaedic physical therapy.

There were several other events of note in 1978. Florence Kendall was awarded "Honorary Membership to the Orthopaedic Section" for her work in helping the Section develop its bylaws. The *Bulletin* was converted to a Journal. Section bylaws were updated. The Acupuncture SIG requested that the BOD consider their becoming a "subsection." And Section membership stood at 3,000—up from 1,800 just one year before, despite a 1977 dues increase to $12.

As the Section grew, a concomitant need for increased information emerged. The Journal had been doing double duty—disseminating news of Section business as well as publishing scientific articles. Section leadership quickly realized that the competing and burgeoning demands of both Section business news and scholarly articles for Journal space could not be reconciled within a single publication. Dues were increased to $20, and as it had earlier, the Section again began publishing a *Bulletin* for news, this time in addition to the Journal. Journal subscriptions stood at 3,572 for Orthopaedic Section members, 1,794 for Sports Section members, and 2,387 for nonsection members. The needs of Section members—as well as nonsection members—were being met.

The Orthopaedic Section had quickly become the largest APTA Section and, as such, recognized its capacity to effect change within the profession by virtue of its dominant position within the national organization. But it also recognized the need to exercise restraint. A quotation from the Summer 1978 issue of the *Bulletin* expressed the sentiment of the times very well:

> We in the Orthopaedic Physical Therapy are in a position to take the lead role in changes that will occur in our profession, ie, certification of the specialist. We must work within the system. Remember we are Physical Therapists first and Orthopaedic Physical Therapists second. Our strength lies in being strong and active members in the APTA and its respective chapters and section, rather than only our section.
>
> The accomplishments of the Orthopaedic Section in its first 6 years resonated throughout the entire physical therapy community: in a profound transformation, the technicians of the 1960s and early 1970s were becoming skilled clinicians capable of evaluating and treating without specific physician referral. Physicians were beginning to respect the assessments and treatments their patients were receiving and started to include physical therapy as an integral component of their treatment of musculoskeletal problems. Orthopaedic physical therapy was coming of age.

Guess who these people are?

Manual and manipulative therapy continued to grow internationally, eventually resulting in the establishment of the International Federation of Manual Therapy (IFOMT), which is the first clinical subsection of the World Confederation of Physical Therapy (WCPT). Only organizations, not individuals, can be members of IFOMT. In order to become a member, an organization's members must each, as individuals, meet IFOMT standards. Within the APTA, there was not a mechanism whereby such a select group can be formed because any APTA member is free to join any Section. Thus, once again there emerged a need to form an Academy—this time the American Academy of Orthopaedic Manual Physical Therapists. The Academy successfully applied for IFOMT membership in 1993 and has since established solid ties with the Section. The President of APTA is the official liaison between the Academy and the APTA.

As Dreams Became Realities: 1980 through 1985

Carolyn Wadsworth, PT, MS, OCS, CHT

Reprinted from *Orthop Phys Ther Practice*. 1999;11(2):10-12.

This article is the second of a 4-part series depicting the Orthopaedic Section history. It covers the period from 1980 through 1985. Stanley Paris and Dorothy Santi eloquently described the events leading to the Section's inception in the last issue of *Orthopaedic Physical Therapy Practice*. They gave us fascinating insights into the challenges and victories that occurred during the 1970s, our Section's formative years. We hardly knew an infancy! With membership doubling every 2 years between 1974 and 1979, we were off the growth chart of traditional human development. You could say that we hit the ground running.

As the Orthopaedic Section embarked upon the 1980s, we faced the stark realization that we must assume *responsibility* for the institution we had created with our youthful energy and enthusiasm. We had come of age. Our founding leadership had tested the waters and established the Section as a significant component of the APTA. It was up to the next tier to devise a plan and guidelines for continuing to achieve our mission. How must we proceed?

The Section was already widely recognized for its intensity, commitment, and vision. Hardly the oldest APTA Section, nevertheless we were the fastest growing and the first to propose the recognition of clinical specialization. We had forged ahead, intent on sharpening our knowledge and technical skills so that we could make an impact on the medical community. We explored and further defined our role as specialists in movement disorders, with proficiency in manual techniques. The Section established many national and international contacts with promises of promoting the scope and efficacy of orthopaedic physical therapy—quite a mission to uphold.

Section leaders in the early-to mid-80s recognized the need to provide a solid, stable framework from which to build and expand. We embarked upon a plan to improve our efficiency by organizing internally. Countless hours and effort went into developing basic operational mechanisms that are now taken for granted. Duane Saunders and Jim Finch contributed to implementing *strategic planning and budgeting*. Carolyn Wadsworth and Bob Deusinger to developing *policies and procedures*, and Dorothy Santi and Dave Johnson to *rewriting bylaws*. We instituted a Section master calendar, an extensive committee structure, and recognition events to provide continuity among past, current, and future activities. Membership involvement was a critical issue, so Jim Gould and Jerry Fogel led us in taking steps to inform members of opportunities and encourage their participation through open forums, an interactive column in the *Bulletin of the Orthopaedic Section*, and absentee balloting. Bob Burles expressed the sentiments of many, stating we had "become an excellent Section because of the dedicated work of a few…(but our) base must be broadened to include input from the mainstream" (*Bulletin of the Orthopaedic and Sports Physical Therapy Sections*, 1981). Rick Ritter said "by utilizing our greatest resource, which is our diverse membership, the needs of the Section can be met" (Bulletin, 1981).

> "We had "become an excellent Section because of the dedicated work of a few...(but our) base must be broadened to include input from the mainstream."
>
> —Bob Burles

We also reached beyond our walls to establish a solid working relationship with APTA. Babette Sanders noted "we as a Section must continue to support APTA activities so that we remain a unified and strong group" (*Bulletin*, 1979). When some Sections were considering withdrawing from CSM, our Section voted in 1980 to continue its commitment to be involved in CSM through 1983. Also, Duane Saunders' (President, 1981-1983) strategic plan stated: "provide for Section representation to the House of Delegates and encourage membership interest and communication regarding House actions" and "maintain contacts with agencies, organizations, and individuals related to the activities of the Section and the physical therapy profession."

Several of our most compelling, ongoing objectives were pursuit of specialization, continuing education, and research. Candidate statements in the *Bulletin*, 1982, provide examples of commonly expressed goals: "to define a scope of clinical expertise through the establishment of Board Certification for specialization in orthopaedics…more emphasis must be placed upon increasing educational prospects to develop greater skill in the treatment of patients" (Janet Yamada); "to continue…the interchange and dissemination of information, identification of available resources, and fostering clinical research in orthopaedic physical therapy requires involvement of more members" (Bob Deusinger); "ensure that these high ethical and clinical standards are upheld…by advancing our education, clinical skills, and professionalism, we will be more capable of dealing with some of the issues facing us in the future" (James Keefe). Rather than give a tedious chronological summary of the ensuing 6 years, this article will summarize the major forces that shaped our Section.

CLINICAL SPECIALIZATION

The long road to specialization was one of the most pervasive challenges facing the Section. From the outset we were committed to the concept of developing and recognizing specialists. Arriving relatively late upon the scene of orthopaedic manual therapy, Americans had both the fortune and misfortune of deriving their training from vast continuing education offerings representing many schools of thought. This made it difficult to consolidate the diverse material into a unified educational model from which an examination could be derived. Assisted by Marilyn Anderson, Chairman of the APTA Committee on PT Competencies, Jim Robinson and Carolyn Wadsworth, representing the Education Committee, wrote

the Orthopedic Competency Document in 1980. Dan Jones (President, 1979-1981) used the competencies to develop the *Petition for the Establishment of a Specialty Area in Orthopaedic Physical Therapy*. The APTA Committee for Certification of Advanced Clinical Competence approved our petition in 1981, along with petitions from the Cardiopulmonary, Pediatrics, and Clinical Electrophysiology Sections. We appointed our first Orthopaedic Specialty Council in 1982, consisting of Eileen Vollowitz, Rick Bowling, and Randy Kessler. The APTA mandated that the Section was to be financially responsible for the Council, but the 2 bodies were to remain separate entities.

The Council announced its first goal was to complete a survey of advanced orthopaedic practice to determine the frequency and criticality of the content areas, or standards, from the competencies. It set 1985 as the target date for the first examination. The Section allocated $13,800 to the Council for its 1983-1984 operating expenses. The Council was not able to complete a preliminary survey until 1985, which they distributed with an application for Subject Matter Experts (SMEs) to Section members. Under Dave Johnson's leadership (Chair, January 1985-June 1985), the council analyzed the applications and selected 45 SMEs and 101 item writers. Betty Sindelar assumed the Chair of the Council in July 1985. She announced plans to complete the task descriptions and an in-depth survey of the SMEs in 1986. The Section budgeted $193,125 for support in 1986. The Council postponed the target exam date to 1987, but even this was not to be; stay tuned for the conclusion in the next article.

SECTION PUBLICATIONS

Our best means for informing our growing membership of events, issues, decisions, and contemporary research was through publications. Since 1976 we had published the *Bulletin of the Orthopaedic and Sports Physical Therapy Sections*, which contained primarily Section news. There was a dire need, however, for a more scholarly publication to disseminate research and clinical practice information. This void was filled in May 1979 with publication of the first issue of the *Journal of Orthopaedic and Sports Physical Therapy*, edited by Jim Gould and George Davies. After 2 issues in the first year, we produced 4 issues through 1982, 5 in 1983, and 6 through 1985. The Orthopaedic and Sports Physical Therapy Sections established the first Journal office at 505 King Street, LaCrosse, WI in June 1984. We continued to publish the *Bulletin* annually, in 1980 by ourselves, and in 1981 through 1983 jointly with the Sports Section. December 1983 marked the beginning of our newly designed *Bulletin of the Orthopaedic Section*. With unique cover art and many new features, it was a big asset to member communications. Chris Saudek served as editor, publishing 3 issues in 1984 and 4 in 1985.

The Orthopaedic and Sports Sections also joined in producing an "abstracting service" in 1982, edited by Vince Basile. Initially subsidized by the Sections, it was projected to soon become self-supporting. Subscriptions, which cost $18, included installments of cards containing abstracts of scientific literature, with a hole-punch retrieval system. By 1984 the Service had over 1000 satisfied subscribers, but due to competition from other resource services, it was difficult to break even on costs. In 1985 the Sections found it necessary to dissolve the Service, and began publishing the abstracts in the *Bulletin*.

LEGAL ISSUES

The Section adopted a motion in 1981 to "study the issue of the legal rights of physical therapists to perform manipulation." Legal counsel advised us to "provide for teaching of manipulation in the educational programs" and "revise...state practice acts to include the term manipulation." Legislative Awareness Committee Chairman, Chuck Byers, reported in 1984 that "only seven states mentioned mobilization in the definition, three states used the term manipulation, while two states included both terms; no states mentioned restrictions prohibiting the use of the terms mobilization and/or manipulation by other health care professions." We then adopted the motion that "the Orthopaedic Section support use of the term mobilization within the definition of physical in state laws and practice acts.

PUBLIC RELATIONS

The 1983 strategic plan objectives included "keep orthopaedic physical therapy and the Section publicly visible in the media nationwide through publicizing of Section events, activities, policies, decisions, and member's achievements." We developed our first PR brochure in 1983, which our members widely utilized. Plans also were underway to develop an exhibit booth. It materialized in 1985, under the supervision of Garvice Nicholson, Public Relations Committee Chairman, and Rick Clendaniel. The first booth consisted of an 8' by 10' silkscreen canvas attached to a collapsible flame, with an accompanying slide tape program, which we displayed at conferences.

OFFICE AND STAFF

Babette Sanders (Treasurer 1977-1981) encouraged the Section to pursue

Our first meeting in the new Winter Park office. Can you identify these people?

nondues revenue to offset the costs of our programs, publications, and Orthopaedic Specialty Council. Success in this endeavor allowed us also to begin modest investing and make contributions to support causes such as research and legislation. The desire for paid office support, however, was well beyond our means during our first decade. Our organization was run entirely by volunteers until July 1985.

When we initially contemplated obtaining office space and/or secretarial assistance in 1983, Jim Finch (Treasurer 1981-1985) estimated it would cost about $55,000, which was prohibitive for us at the time. By 1985 we had saved enough to consider contracted services. Carolyn Wadsworth (President 1983-1985) and Bob Deusinger (President 1985-1987) drafted a job description and contract for a part-time executive secretary, and began soliciting applications. At our 1985 annual meeting we decided to contract with Pat Kirkbride, Association Resources, Inc., Winter Park, FL, pending approval of a vote to increase dues from $20 to $30 (regular members), $15 to $20 (affiliate member), and $10 to $15 (student member). The membership approved the dues increase and we officially signed the contract on July 1, 1985. The Executive Committee took immediate action to transfer all documents and records to our new headquarters in Florida, and to institute the necessary training for Pat and her staff. With great pleasure, we held our Fall Executive Committee Meeting in our new office!

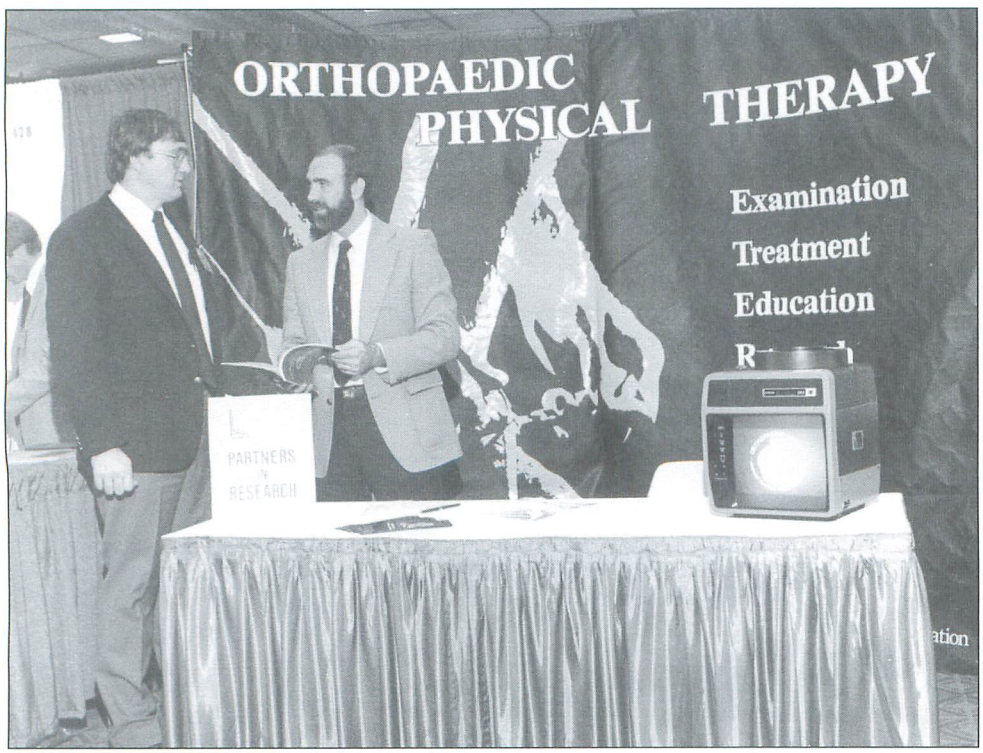
OTHER SIGNIFICANT EVENTS

1980 Section raised over $4,500 for APT-CAC with "Sea Food Bonanza"
1981 Section began investing funds
1983 Section donated $10,000 to the Foundation for Physical Therapy for research
1983 Section had 25 study groups
1983 Section initiated absentee balloting
1983 Section held first fall executive committee meeting
1984 Section computerized financial data
1984 Section copyrighted logo
1985 Section incorporated to Delaware

SUMMARY

By the close of 1985 we had reached "thirty-something." We had matured and were becoming comfortable with our stature. As a large body with a common interest, we had pooled our assets to produce a phenomenal organization of which we were proud. The Section now had a roof over its head, and was moving toward financial security. We had hired personnel to manage logistics so that our officers and committee chairs could spend more time developing innovative ideas and planning for the future. Bob Deusinger proposed that perhaps now it was appropriate to begin thinking about the Section and role of the orthopaedic physical therapist in a NEW WAY (*Bulletin*, September 1985). At this time we had the stability to face new challenges.

Carolyn Wadsworth, PT, MS, CHT, OCS is owner of Heartland Physical Therapy in Cedar Rapids, Iowa.



Garvice Nicholson at our first Orthopaedic Section booth.

Growth: 1985 through 1992

Nancy White, MS, PT, OCS

Reprinted from *Orthop Phys Ther Practice*. 1999;11(3):8-10.

This article is the third in a 4-part series celebrating the history of the Orthopaedic Section over the past 25 years. The first 2 articles written by Stanley Paris, Dorothy Santi, and Carolyn Wadsworth described the enthusiasm, vision, and ideals of the founding members and the dedication and perseverance of those who were committed to developing a strong organization to accomplish their goals. This article covers the time period between 1985 and 1992.

The Section's first decade was marked by tremendous growth and by the establishment of priorities including: achieving specialist certification, protecting the practice of orthopaedic physical therapy, and obtaining national and international recognition for the Section and its members. The second decade will be remembered by many for the achievement of several of these goals and for the significant steps we took toward the accomplishment of others. Recognition of the orthopaedic clinical specialist, the development of high-quality educational programs for Section members, and the emergence of the Section as a major contributor to physical therapy research were all highlights during this time period.

SPECIALIZATION

Hundreds of Section members contributed literally thousands of hours and untold amounts of energy to the dream of achieving recognition of specialty practice in orthopaedic physical therapy. It is the Section's hope that several of these individuals will contribute to a later article highlighting the dreams, frustrations, and victories that occurred along the road to specialization.

Steve Rose at the inaugural Black Tie & Roses in 1998.

It was the strong feeling of many of the early proponents of specialization that a practical examination was necessary to adequately assess the skill level of physical therapists seeking recognition as orthopaedic clinical specialists. Considerable time, energy, and financial resources were spent in an attempt to develop and validate a combined practical and written examination. Because of the numerous and varied approaches utilized in orthopaedic physical therapy practice in the United States in the 1980s, it became clear that reaching consensus on a practical examination by the agreed upon deadlines was close to impossible. The target examination date had been extended numerous times and both financial and human resources were running short.

The Orthopaedic Competency Document, originally written by Carolyn Wadsworth and Jim Robinson, was finalized by Betty Sendelar, Eileen Volowitz, and Richard Bowling. This document was finally approved by the American Board of Physical Therapy Specialties (ABPTS) in 1987. This provided the blueprint for the Specialty Council to put the finishing touches on the exam and set a date for its administration.

In April 1988, the members of the Orthopaedic Specialty council and subcommittees resigned with the disagreement with the ABPTS regarding the inclusion of a practical component for the examination could not be resolved. Addition of a reliable and valid practical examination was not ruled out for future examinations.

In May 1988, Section President Jan Richardson appointed a new Specialty Council. The new Council members, Joe McCulloch (Chair), Rick Ritter, and Susan Stralka, utilized the work of previous Specialty Councils to prepare and administer the examination. The Orthopaedic Competency Document and hundreds of test items developed under the leadership of previous Specialty Councils were used by the new council to finalize the examination.

Final approval of the application process and the criteria to sit for the examination were approved by the ABPTS in 1988. By September 1998, all test items were ready for the meeting between the Specialty Council and the testing agency for final examination development. Due to a sudden change in testing services, the process was again put on hold and a new examination date was set for June 1989. With the new date set, the Specialty Council spent many long days with test preparation consultants reviewing, referencing, and refining each test item. It was clear that accurately defining advanced clinical practice and ensuring that the examination reflected this practice would be an ongoing process. But the first examination was finally ready!

The first specialist examination was administered on-site on June 19, 1989, at APTA's Annual Conference in Nashville, Tennessee. Twenty-six individuals passed the exam and became the first Board Certified Specialists in Orthopaedic Physical Therapy.

The Specialty Council continued its work to refine the examination and to add additional questions to the item bank through the continuation of item writer workshops. Specialty Council member, Mary Milidonis, prepared a 1-year plan to develop the Description of Advanced Clinical Practice in Orthopaedic Physical Therapy that is used today. By 1992, there were 185 Board Certified Orthopaedic Clinical Specialists.

The topic of a practical examination continued to be discussed and debated. Several members who originally fought hard for the inclusion of the practical component realized the ongoing difficulty in developing and validating such an examination. Many of these individuals began the early work toward a goal that is finally being realized today—the certification of clinical residency programs. It is the hope of the Section that the dreams of the early pioneers in orthopaedic physical therapy specialization will finally be realized with a combination of a written examination and a certified clinical residency program.

EDUCATION

The Orthopaedic Section has always enjoyed a strong reputation for providing high-quality, low-cost, educational pro-

grams for its members. The Education Committee Chairs, Jan Richardson (1985-1987) and Annette Iglarsh (1987-1992), deserve much of the credit for the tremendous growth in the area of post-professional continuing education within the Orthopaedic Section.

In support of clinical specialization, the Section developed the continuing education course, Review of Advanced Competencies in Orthopaedics. The course was first held in 1988 and was tremendously popular among physical therapists preparing for the specialist examination. The course continued to be offered on an annual or semi-annual basis for 8 years and was held in different geographic regions. Section officers attended these courses and held small, informal membership meetings in an attempt to reach Section members who might not regularly attend national meetings.

The first meetings to discuss the production of a home study course were held in 1988. Continuing education was becoming mandatory in many states and financial pressures were making travel to courses difficult for many physical therapists. After an initial attempt to contract with an outside publisher, the Section began the in-house publication of its tremendously popular Home Study Course series. Annette Iglarsh, Chair of the Education and Program Committee worked to develop the series. Kent Timm served as the first Editor and Sharon Klinski was Managing Editor.

Educational programming at Combined Sections Meetings also grew tremendously during this time period. The development of Special Interest Groups and Roundtables led to the need for specialized programming. In addition to combined programming with other Sections, the Orthopaedic Section began offering specialized programming in occupational health, manual therapy, performing arts, foot and ankle, head and neck, and pain management. During this time period, the Orthopaedic Section's program for CSM progressed from a simple, half page offering with no overlap of programs to the extensive, highly-specialized program that we enjoy today.

RESEARCH

From 1985 to 1992, Section Presidents Jan Richardson and Bob Deusinger helped to establish the Orthopaedic Section as a strong supporter of physical therapy research. Due in part to the success if its educational programs, the Section had the financial ability to demonstrate this commitment through gifts to the Foundation for Physical Therapy. Because of this early commitment, the Orthopaedic Section became a leader in funding research to evaluate the effectiveness of orthopaedic physical therapy practice.

AAOMPT members gather for a pre-CSM joint program.

In 1988, the Orthopaedic Section recognized the vision and contributions of one of its members, Steven J. Rose, with the development of the Rose Excellence in Research Award. This award was announced at the first annual Black Tie and Roses Reception, which was held in Dr. Rose's honor at the Combined Sections Meeting in Washington, DC. The Section also established the Steven J. Rose Endowment for Orthopaedic Research for the Foundation for Physical Therapy.

The physical therapy community and the Section experienced a tremendous loss with the death of Steve Rose in 1989. Dr. Rose's contributions to the Section and to physical therapy continue to be recognized and will long be remembered.

PRACTICE

Several practice issues dominated the discussions at Section meetings during this time period. The Position Statement on Manipulation was developed and adopted in 1990. It was recommended at that time that schools show evidence of educational preparation of physical therapists to perform manipulative techniques and that states work to ensure that laws are protective of this practice.

Referral for profit continued to be discussed and debated. The ongoing dilemma of delegation and supervision of physical therapist assistants and physical therapy aides was discussed. Surveys were taken and forums were conducted to determine a consensus among the membership. Although little consensus appeared to exist, the leaders of the Section used the available information to begin to develop a plan for appropriate utilization of support personnel.

The formal development of Special Interest Groups (SIGs) began with the recognition of the Industrial Physical Therapy (now known as Occupational Health Physical Therapists) SIG in 1992. Susan Isernhagen chaired the newly formed group. Founding of the Performing Arts Physical Therapy SIG, the Foot and Ankle SIG, and the Pain Management SIG quickly followed. The result of this development was a broadening in scope of a Section that was originally founded by individuals with a primary interest in manual therapy. The Section realized that its mission included representation of members in a wide array of practice settings. The Special Interest Group development served to provide a mechanism for members in various orthopaedic practice settings to exchange clinical information, provide education, define and protect practice, and promote and support research. The Section was strengthened in ways it had not expected!

PUBLIC RELATIONS

The educational programs and financial gifts to the Foundation resulted in significant public relations for the Orthopaedic Section within the physical therapy community. Membership in the Section grew from 5,269 to 11,527 between 1985 and 1992. The public relations committee chairs during this time period, Garvice Nicholson, Jonathan Cooperman, and Karen Piegorsch devel-

oped the Section's exhibit booth and brochure and began exhibiting at medical meetings throughout the country.

SECTION PUBLICATIONS

With over 10,000 members, the Section's primary means of reaching its members was through its publications. The *Journal of Orthopaedic and Sports Physical Therapy* (*JOSPT*), edited by Jim Gould and George Davies, became a monthly publication in 1986 and continued to be one of the Section's greatest benefits for its members. Thanks to the tremendous work of its editors and the support of both the Orthopaedic and Sports Sections, *JOSPT* continued its development from a newsletter for clinical exchange of information to a scholarly publication. Double-blind review of articles submitted for publication began in 1988.

In 1990, Gary Smidt was hired as the new editor of *JOSPT* and the journal office was moved to Iowa City, Iowa. Recognition of the *JOSPT* in Index Medicus had been a goal of the Section for several years. After numerous attempts, this goal was finally reached in 1992. By this time, *JOSPT* had a full editorial board and had grown both in popularity and respectability.

The *Bulletin of the Orthopaedic Section*, the Section's primary means of communicating Section news to its members, underwent another transition during this period. With the evolution of *JOSPT* to a more scholarly publication, the need existed for a means of exchange of clinical information on a more informal level. In 1989, the Bulletin was renamed *Orthopaedic Physical Therapy Practice* (*OP*) and was modified to include a combination of Section news, legislative and practice issues, and clinical articles. Christine Saudek was the Editor for the first year of publication. John Medeiros became editor in 1990 and initiated the practice of writing editorials relating to practice issues. Often controversial, and never tame, these editorials have become a tradition. Members who had never found time to read this publication now at least began opening the front cover!

ADMINISTRATION

The tremendous growth in membership resulted in a need for additional support and office space. Since its inception in 1979, the *JOSPT* office had been located in LaCrosse, Wisconsin. In 1985, the Section moved its office to Winterpark, Florida, and contracted with Pat Kirkbride to administer the Section's business. The following year, the Section relocated its headquarters to 505 King Street in LaCrosse, and David Thomack was hired to replace Pat Kirkbride as the Administrative Director. The Section's first computers were purchased for membership and financial records shortly after this move. The Section's growing staff and expanding programs soon resulted in a need for more space. In 1989 the Section moved into a larger office within the same building. Terri DeFlorian (then Pericak) was hired as David Thomack's assistant. With David's departure in 1990, Terri was promoted to Administrative Director.

The development of the Section's educational programs and publications resulted in the need for additional staff. In 1990, Sharon Klinski was hired to coordinate the Section's publications. Tara Fredrickson was hired in 1993 to coordinate the educational courses and to serve as Terri's assistant.

The Section's budget grew from $200,000 in 1985 to $1,300,000 in 1992. This increase was due to the growth in the Section income resulting from the successful educational courses and the expenses associated with providing these new member benefits. Treasurers, John Wadsworth and Bob Burles, provided great leadership in financial planning and investments during this time of growth. Bob is also credited with bringing the Section into the computer age and earned the title "Mr. Wizard" for his skills and persistence.

By the early 90s, the Section was again outgrowing its space. The Board began discussing the possibilities of purchasing land and building a building to house the Section office They didn't realize how quickly this idea would become a reality!

SUMMARY

The period of time between 1985 and 1992 was a time of tremendous growth for the Section. The successful educational programs provided wonderful member benefits and were a great source of public relations and revenue for the Section. The leadership kept the Section strong by wise planning and innovative programs. They were successful in implementing specialization in orthopaedic physical therapy and built the groundwork for certification of clinical residency programs. The Section was a leader among APTA components in funding research in physical therapy and set the standard for others to follow,

The possibilities for the Section seemed unlimited in 1992. Demand for physical therapy in the health care arena had grown tremendously and times were great for physical therapists. Fortunately, the Section had laid the groundwork for practice protection and had the financial and organizational strength to be prepared for the challenges that lay ahead.

Nancy T. White, MS, PT, OCS is currently serving as Vice President of the Orthopaedic Section and a Board of Trustee for the Foundation for Physical Therapy.

OTHER SIGNIFICANT EVENTS

1989—First Rose Excellence in Research Award presented to Don Neumann, PhD, PT, Gary Soderberg, PhD, PT, and Thomas Cook, PT for their article "Comparison of Maximal Isometric Hip Abductor Torques Between Hip Sides."

1990—Section celebrated 15th Anniversary (one year late!) with a gala featuring entertainer Nancy Wilson.

1990—First Paris Distinguished Service Award presented to Stanley Paris, founder of the Orthopaedic Section.

1992—Jim Gould received the Paris Distinguished Service Award.

1992—The American Academy of Orthopaedic Manual Physical Therapists (AAOMPT) was formed and held its first meeting in Vail, Colorado. The Orthopaedic Section began both formal and informal dialogue with the AAOMPT in an attempt to coordinate efforts and discuss topics of concern and interest to both groups. Recognition of clinical residency programs was a priority of the founding members of AAOMPT.

Partnerships for Survival: 1993-1999

Joe Farrell, PT, MS, FMAAOMPT

Reprinted from *Orthop Phys Ther Practice*. 1999;11(4):7-10.

Within a couple of months the Orthopaedic Section will enter the new millennium prepared with a sound strategic plan (developed by our Board of Directors in September 1998) to deal with unpredictable health care and political environments, as well as a turbulent global economy. In the early 1990s, under the leadership of Section President Jan Richardson, PT, PhD, OCS, our Section leaders predicted that our organization required a higher degree of stability to survive any political and health care environment. This notion was passed on to Section President Annette Iglarsh, PT, PhD when she began her tenure in 1992. It became evident that early in the decade of the nineties, our leaders had the foresight to treat the Orthopaedic Section "as a business." A dynamic process of crafting a sound financial plan to keep Section overhead at a minimum, generate nondues revenue, continue competitive educational programs for our members, and advance our profession publicly and politically, really evolved as the Section membership and its leaders matured.

The health care arena has changed immensely since 1992. Managed care, corporatization of health care, and fierce competition for health care dollars between various health care providers has lead our Section to partner with the American Physical Therapy Association (APTA), American Academy of Orthopaedic Manual Physical Therapists (AAOMPT), Sports Physical Therapy Section, and State Chapters to deal with dynamic changes in physical therapy practice. We have worked together to promote clinical research, education, specialization, publications, and legislative initiatives.

This article is the last in a series of 4 articles which represents an attempt to document important aspects of the rich 25-year history of the Orthopaedic Section. It is very difficult and tedious to record a concise history of any organization; therefore, I choose to highlight important events of the past 6 years relating to partnering for the long-term survival of the Section. Included in this article will be highlights relating to administration, practice issues, publications, clinical residency credentialing, the 25th anniversary celebration in Seattle, Washington, and awards. I trust this format will rekindle the memories of long time members and stimulate our new members to become more involved with our great Section.

Ribbon cutting ceremony of our new office building, November '95.

ADMINISTRATION OF THE SECTION

Late in 1992 Richardson began to allocate finds for the construction of a new, self-funded office space to house the Section operations. This decision was based on the demands of a growing Section membership and potential office responsibilities that would require expansion of costly rental office space. Enhancing future financial stability was the primary objective for initiating the purchase of land the eventual construction of a building for the Section. Through astute financial planning of our Finance Committee (lead by Treasurers John Wadsworth, PT, MA and Dorothy Santi, PT), the land and office building would be fully paid for prior to construction.

Four acres of land were purchased in 1995 on a beautiful site overlooking the Mississippi River in LaCrosse, Wisconsin. The long-term plan was to build the Section office on one acre and subsequently sell the remaining 3 acres. Ground breaking for the new building took place on June 12, 1995. Terri DeFlorian, the Section Executive Director, engineered the transition and move into the new office building on November 3, 1995. A local grand opening took place with the Chamber of Commerce present to conduct a ribbon cutting and officially welcome the Section to LaCrosse. Section President Bill Boissonnault, PT, MS, DPT led a group of 40 people from local businesses, hospitals, and the University of Wisconsin LaCrosse.

The official grand opening of the East River Professional Park which houses the Section offices took place on October 5, 1996. Officers (President, Boissonnault; Vice President, Nancy White, MS, PT, OCS; Treasurer, Santi; Directors, Elaine Rosen, DPT, OCS and Mike Cibulka, PT, MHS, OCS) and Committee Chairs were joined by Past Presidents Stanley Paris, PT, PhD; Carolyn Wadsworth, PT, MS, OCS, CHT; and Jan Richardson along with past Vice President John Medieros, PT, PhD. Boissonnault dedicated the conference room to the memory of James A. Gould, PT, MS. George Davies, PT, MEd, ATC, SCS, CSCS President of the Sports Section utilized this occasion to offer historical notes of the Section and how Jim had touched and inspired many lives and careers. Special guest, Debbie Gould, presented the Section with a picture of Jim that is now displayed next to a plaque designating the *James A. Gould Conference Room*. Boissonnault closed the dedication with the following quote: "Today we honor Jim and Debbie Gould by naming this room the James A. Gould Conference Room. But we will honor Jim even more by the decisions that we will make in this room. I believe Jim's presence will help insure that decisions made here will be made in an intelligent, thoughtful, and constructive manner. It is in this way Jim will continue to contribute to the growth and advancement of the Section."

The business of the Section grew from a 1993 year-end budget of $1,013,828.79 to an annual budget of $1,565,577.00 in 1999. Since 1995 the Section has contributed $500,000 to the Foundation for Physical Therapy for clinical research. The Section developed the Clinical Research Grant Program in 1996. The purpose of the program is to fund clinical research studies by members. A total budget of $30,000 has been allocated for grants annually.

During the autumn of 1996, the Section went on the Internet. Tara Fredrickson, Executive Assistant for the Section, has become our technical wizard. She had developed our Web page and serves as the Webmaster. Recently

(October 1999) our Media Spokesperson Network (MSN) has been linked to our Web page to insure rapid deployment of information to our members and the media throughout the country. Terry Randall, PT, MS, OCS, ATC, Public Relations Chairperson, has worked hard with Rick Watson, PT, Director of the MSN, to complete the link between our Web page and the MSN. In April 1999, Randall was named to the APTA Public Relations Advisory Council. This appointment is a vital partnering link to the APTA Public Relations Department.

During 1998 one last administrative event occurred. The Finance Committee advised the Section in 1997 to restructure the office to insure that adequate training of staff occurred, in particular "cross training" of staff. It was felt that cross training was important because of the changes that occurred in the Publications Department in 1998 (see section on publications). DeFlorian led the transition and training, as well as developing the Measurable Performance Objectives (MPO), which formulated staff performance evaluations and criteria for bonus/financial advancement of the office staff. The MPO format of staff evaluations were effective in 1998.

PRACTICE

Considerable change in clinical practice began after the 1992 presidential election. Despite the failed Clinton administration Health Care Reform push to insure every American, the insurance industry independently changed the system. Managed care evolved, which essentially required providers to share in the financial risk of patient care. Acutely aware of the potential for drastic changes in reimbursement, as well as practice infringement, the Council of Section Presidents (1993) formed a committee to monitor clinical practice issues. Scott Stephens, PT, MS (Chair of the Orthopaedic Section Practice Committee) spearheaded this committee. This committee would enable Sections and the APTA to coordinate their activities and resources to more effectively deal with health care reform and practice infringement issues. Concurrently, the Orthopaedic Section formed a task force consisting of Stephens, Santi, and Medieros to further study health care reform, reimbursement, and encroachment of orthopaedic physical therapy practice. The findings of this task force were reported at the 1994 Combined Sections Meeting (CSM) Practice Issues Forum which was attended by 30 therapists. Of concern at this point in time was the fear that physical therapists would be legislated our of the industry and not be reimbursed for physical therapy services. In addition, changing referral patterns, shifting of private practice into the corporate setting, introduction of private insurance networks, and hospital preferred provider organizations (PPO) changed the manner in which physical therapists practiced on a daily basis.

Secondary to reimbursement issues, the American Chiropractic Association (ACA) in 1996 sought to be included in a managed care organization (MCO) in California. The ACA lobbied the Health Care Finance Administration (HCFA) and essentially won the right to be included in MCOs in the state of California, which meant that the ACA had utilized its financial resources and lobbying skills to provide spinal manipulation in an MCO. Although this ruling only applied in the state of California, the ACA continued a long-term battle to become the primary providers of conservative care for all orthopaedic patients. The desire to become primary providers of conservative care also had been recognized for many years by the Orthopaedic Section leadership. The Americal Academy of Orthopaedic Manual Physical Therapists (AAOMPT) had been working with the Section leadership since 1992 on practice issues. In 1997 Boissonnault observed an opportunity to develop a stronger partnership between the Orthopaedic Section and the AAOMPT to collaborate on practice issues. The appointment of Steve McDavitt, PT, MS, MTC as Co-chair of the Orthopaedic Section's Practice Committee provided a direct link between the Orthopaedic Section and AAOMPT and Helene Fearon, PT, Co-chair provided a direct link between the Orthopaedic Section and APTA's Committee on Practice.

Rosen began organizing and accumulating information relating to manual therapy/manipulation practice and legislative issues in 1995. With the help of numerous individuals and the Practice Committee Chairs (Fearon and McDavitt) the *Compendium of Manual Therapy Practice and Legislative Issues* was compiled as a resource for State Chapters and our members. Included in the Compendium is information that is categorized, alphabetized, and summarized for ease of use to assist the Chapters in protecting the clinical practice of physical therapy.

Since 1994 there have been numerous Practice Issue Forums sponsored by the APTA and the Orthopaedic Section. In June of 1999, at an APTA/Section-sponsored Manipulation Forum at the APTA Scientific Meeting Exposition (SME), it was reported that 19 State Chapters were dealing with legislative issues relating to a physical therapist's right to utilize manual therapy/manipulative procedures in clinical practice. In the short period of 6 months, legislative battles on the State level relating to manipulation had increased from 6 to 19 states. It was evident that the ACAs plan to legislate physical therapy out of the conservative care market place had gained in momentum. During the Manipulation Forum in June 1999, Boissonnault and Orthopaedic Section Director Joe Farrell, PT, MS, FMAAOMPT voiced an urgent concern that our profession requires a long-term plan of action to protect our clinical practice as outlined in the *Guide to Physical Therapist Practice*, which was published in 1997. Thus Farrell organized a Manual Therapy and Manipulation Strategic Planning Meeting at the APTA National Headquarters in September 1999 that was attended by the APTA Government Affairs staff, Section leaders, State Chapter Presidents, President of AAOMPT, and a group of educators. The outcome of this meeting was positive in that a long-term proactive plan of action was formulated to strongly address manipulation issues and any other professional encroachment problems that may arise in the future. The plan of action will be presented to the APTA BOD for consideration in November 1999.

Clinical practice since 1993 has become more specialized. In 1993 the first Special Interest Group (SIG), Industrial Physical Therapy, became part of the Section. In 1995, the Industrial Physical Therapy SIG, changed its name to the Occupational Health Physical Therapists SIG (OHPTSIG). In 1996 the idea for the "Compendium on Occupational Health Physical Therapy" was conceived by the OHPTSIG. The development of the Compendium has been a joint venture of the Section, APTA, and OHPTSIG. The OHPTSIG hopes to complete the Compendium for distribution by the end of 1999.

Other SIGs developed through a mechanism whereby interested physical therapists formed a roundtable group. When the roundtable group was able to acquire 250 signatures of interested physical therapists, then the roundtable was eligible to become a SIG upon approval of the Section BOD. Special interest group status provided a "house" for physical therapists with a special interest to meet, confer, and share educa-

tional ideas. In 1999, there are 5 SIGs serving the needs of membership: OHPT-SIG, Performing Arts SIG, Foot & Ankle SIG, Pain Management SIG, and the Animal Physical Therapist SIG. The AAOMPT remains an external organization to the Section (not a SIG) which communicates regularly on practice and residency credentialing issues through an official liaison from the APTA and the Section. In retrospect, the SIGs have contributed significantly to the programming for the annual Combined Sections Meeting and practice issues.

PUBLICATIONS

During the summer of 1993, the *Journal of Orthopaedic and Sports Physical Therapy* (*JOSPT*) editor Gary Smidt, PT, PhD reported that after 14 years *JOSPT* had joined 3,055 international journals indexed by the National Library of Medicine (Index Medicus). The great accomplishment under the direction of Smidt enhanced the worldwide acceptance of *JOSPT*.

In June 1996 at the APTA Annual Conference in Minneapolis, the Orthopaedic and Sports Sections received a pessimistic financial report from the publisher (Williams & Wilkins) regarding *JOSPT*. The goal of the Orthopaedic and Sports Sections was to continue publishing a quality journal without increasing the cost to Section membership. Therefore, Boissonnault and Davies and their respective BODs issued a request for proposals for publication of *JOSPT*. Seven proposals to publish the journal were received by the January 15, 1997 deadline. Davies, Boissonnault, and an independent consultant reviewed the proposals. In May 1997 the Executive Committees of the Orthopaedic and Sports Sections narrowed the field of potential Journal publishers to two: Williams & Wilkins and Allen Press, Inc. After extensive negotiations, Allen Press, Inc, was selected to publish *JOSPT*. With the Williams & Wilkins contract ending December 31, 1998, the transitioning of publishing responsibilities began in July 1998. The financial terms of the contract will allow the Sections to provide adequate resources for continued growth of *JOSPT*.

Concurrently while negotiations for a new publisher were ongoing, the Editor-in-Chief Search Committee (Dan Riddle, PT, White, Santi, Davies, and Mark DeCarlo, PT, MS) interviewed 5 candidates. After considerable deliberation, the search committee selected Richard DiFabio, PT, PhD from the University of Minnesota as the new Editor-in-Chief of *JOSPT* in the lat[illegible] 1998. DeCarlo (current Presi[illegible] ports Physical Therapy Section) and DeFlorian administrated the move of the *JOSPT* office from Iowa City to the Section's LaCrosse office building. In addition, DeCarlo set up the BOD for *JOSPT* and with DiFabio's assistance set up the first meeting on July 7, 1998 in the new editorial office with Allen Press. DiFabio selected a new editorial board for the journal that officially met in LaCrosse with the Section's BOD on September 25-26, 1998. The first issue under DiFabio's leadership occurred in January 1999. In sum, during 1998, the Section transitioned from one publishing company to another, one Editor-in-Chief to another, and moved the Journal office from Iowa City to LaCrosse. This would not have been possible without the sound financial stability of the Section that had commenced during Presidents Richardson's and Iglarsh's tenure in the early 1990s and the expertise and negotiation skills of Presidents Boissonnault and Davies.

Other important components of publishing relate to contracted journals, *Orthopaedic Physical Therapy Practice*, and Home Study Courses. The Section continues to operate "as a business" to maintain financial stability and to contribute hundreds of thousands of dollars to clinical research and practice-related issues. Due to our work in publications, the Section is earning nondues revenue. For example, the Section's Managing Editor, Sharon Klinski, manages a significant workload. Contracted journals Klinski manages include: *Cardiopulmonary Physical Therapy Journal*, *Issues on Aging*, *Neurology Report*, *Oncology Rehabilitation*, and the *Section on Women's Health Journal*. In addition, she is also working consistently with the following newsletters: *Geri-Notes*, *Hand Prints*, and *Highlights of the Section on Women's Health*.

Since the evolution of *Orthopaedic Physical Therapy Practice* (*OP*), Klinski has worked as the Managing Editor for *OP* Editors Medieros, Jonathan Cooperman, PT, JD, OCS, and our current *OP* Editor, Susan Appling, PT, MS, OCS. Historically, the cover of *OP* changes format and color in the winter of 1993 and again in the winter of 1997. The 1997 issue of *OP* denoted the publication as *Orthopaedic Physical Therapy Practice: The Newsletter of the Orthopaedic Section, APTA*. The January 1999 (Vol. 11, No. 1) issue of *OP* again changed in terms of title: *Orthopaedic Physical Therapy Practice: The Magazine of the Orthopaedic Section, APTA*.

The Home Study Course (HSC) series has evolved considerably since Kent Timm, PT, PhD, OCS, SCS, ATC, FACSM was the first editor of this popular educational offering for the Section's membership. Current Home Study Course Editor, Wadsworth has provided an eclectic offering of HSC programs ranging from occupational health, orthopaedic/sports-related topics, and medical topics pertaining to pharmacology and diagnostic imaging of bones and joints. Over 2500 registrants have taken advantage of the HSC to earn CEUs and advance professional knowledge in a cost-effective manner.

CLINICAL RESIDENCY CREDENTIALING

Accreditation of Clinical Residency Programs was initiated with the formation of AAOMPT in 1992. The AAOMPT worked in collaboration with Section Presidents Richardson and Iglarsh in the early 1990s to formulate a plan to accredit residency programs. In March 1994, Carol Jo Tichenor, PT, MA chaired the original 8-member clinical residency accreditation task force appointed by the APTA BOD. Starting from scratch, this group under Tichenor's leadership laid down the foundation for the current process and documentation. The popularity of this mode of advanced clinical training was evident when 400 physical therapists attended a Clinical Residency Open Forum held in Reno, Nevada during the 1995 Combined Sections Meeting. That same year, 400 physical therapists completed a clinical residency survey developed by the original task force of 1994. In 1997, 180 physical therapists reviewed the residency program credentialing guidelines proposed by a third task force chaired by Boissonnault. The feedback received resulted in significant modifications in the document that went to the APTA BOD in November 1997.

The APTA BOD at their November 1997 meeting agreed to implement a postprofessional clinical residency credentialing process, beginning in January 1998. To monitor this process, a 5-member committee on clinical residency credentialing was appointed. The APTA BOD selected Cibulka, Jay Irrgang, PT, Joe Godges, PT, MS, OCS, Colleen Kigin, PT and Toby Long, PT to serve on this important committee. The credentialing guidelines provide requirements for those interested in developing a postprofessional clinical residency program in any specialty of physical therapy. This process will be dynamic and require

nuturing to succeed. Richardson was part of all 3 APTA clinical residency task forces, therefore she was a constant thread linking efforts from 1994 to 1997. Her persistent support for this concept of advanced clinical training was and remains vital to the successful outcome of the credentialing process.

Past Orthopaedic Section Presidents: Stanley Paris, Dan Jones, Duane Saunders, Carolyn Wadsworth, Jan Richardson, Annette Iglarsh, and Bill Boissonnault.

At the Seattle CSM the Orthopaedic Section BOD agreed to allocate $10,000 during 1999 for clinical residency program grants. The grants are designed to cover the APTA credentialing application fee, which ranges from $1500 to $2500 depending on the number of residents in the program. Also during 1999, the Orthopaedic Specialty Council recognized clinical residency training as one avenue to become a clinical orthopaedic specialist.

THE 25TH ANNIVERSARY CELEBRATION

Farrell, Wadsworth, and Linda Weaver (Executive Secretary of the Section) began organizing the archives of the Section's history according to the "Guidelines for the APTA Component Archives" in January 1998. Documentation included minutes from meetings, bylaws, public relations materials, publications from the beginning of the Section's history, home study courses, and lists/photos of all Section Award recipients. At the 1998 BOD Fall Meeting in LaCrosse, Paris, White, Ann Grove, PT, Santi, Farrell, Wadsworth, and Weaver catalogued hundreds of Section photos. Farrell videotaped Paris, Grove, and Santi who gave their impressions of the initial meeting of the North American Academy on Manipulative Therapy in August of 1968.

The 25th Anniversary CSM Meeting was highlighted by quality clinical and education programming. The Section's Education Committee, chaired by Lola Rosenbaum, PT, MHS, OCS contributed an immense amount of energy in planning not only the education program for CSM, but the entertainment for the 25th celebration.

Saturday evening started with a packed house to honor the Section award recipients that included Santi (Paris Distinguished Service Award), Christopher Powers, PT, PhD (Rose Excellence Award in Research), and Walter Jenkins, PT, MS, ATC (Award for Excellence in Teaching Orthopaedic Physical Therapy). Following the Awards ceremony, hundreds of members spent a wonderful evening enjoying great entertainment that included a comedian and a little gambling at a casino night. Weaver was busy most of the night expanding our Section's archives by photographing officers, committee chairs, and past presidents who were present at the celebration. The fast-paced evening capped a great 25th anniversary celebration of the Orthopaedic Section.

SUMMARY

The Vision of the Orthopaedic Section that follows was crafted by the current Section Board of Directors during a strategic planning meeting in September 1998: "The Orthopaedic Section is the leader in advancing orthopaedic physical therapy practice through professional development and increased involvement of our members. The Section leads through bold and innovative education, practice, and research initiatives while maintaining fiscal and ethical accountability."

The period between 1993 and 1999 has provided innovative education through CSM programming and Home Study Courses, which are every popular amongst our members. The Section has shown fiscal responsibility by purchasing land in LaCrosse, Wisconsin, building the East River Professional Building that now houses the Section office and *JOSPT*, changing *JOSPT* publishers, offering numerous Home Study Courses, and publishing journals to provide long-term financial stability of our Section. Our commitment to research since 1993 is incredibly strong in that the Section has donated over $500,000 to the Foundation for Physical Therapy for clinical research and remains very committed to clinical residency training by creating a grant program for residency programs who desire to participate in the APTA Credentialing process. The Section is a strong advocate of protecting the clinical practice of physical therapy as exemplified by its partnering with the APTA, AAOMPT, and other APTA Components to be a "watch-dog" for changes in reimbursement and practice infringement.

Future challenges that face our members include experiencing unemployment during 1999 for the first time in physical therapy, attempting to secure direct access, and recognition of our ability to diagnose by insurance carriers and legislative bodies. Partnering with other component organizations within our profession has enabled us to win many legislative battles since 1993. With a decrease in APTA membership this year, however, perhaps the biggest challenge in the immediate future is increasing our membership to strengthen our profession and our ability to remain a strong political power within the medical and legislative communities. Historically our profession has found a way to succeed and has found ways to survive. Our Section is confident that we will meet challenges as we approach the millennium.

Awards Summary (1993–1999)

Paris Distinguished Service Award:
1995, Joe Farrell; 1997, Rick Ritter; 1998, Carolyn Wadsworth; 1999, Dorothy Santi

Rose Excellence Award for Research:
1993 & 1994, Anthony Delitto; 1995, Karen Hayes; 1996, Lynn Snyder-Mackler; 1997, Richard DiFabio; 1998, Diane Jett; 1999, Christopher Powers

Award for Excellence in Teaching Orthopaedic Physical Therapy:
1995, Sandy Burkhart; 1996, Phil McClure; 1997, Tom McPoil; 1998 Paul Howard

Joe Farrell, PT, MS, FMAAOMPT is currently serving as Director of the Orthopaedic Section, APTA and is owner of Redwood Orthopaedic Physical Therapy, Inc. in Castro Valley, California.

1999-2003
A Time of Strategic Activity

Michael T. Cibulka, PT, MHS, OCS; William Boissonault, PT, DPT, MS

As the Orthopaedic Section celebrates its 30th anniversary at CSM 2004, we will highlight some of the important events that transpired over the last 5 years. The driving force behind the decisions and activities that marked this busy period was the strategic plan adopted by membership at CSM, and finalized at the 1998 Annual Conference. Under the guidance of Jody Gandy of APTA a very aggressive plan was developed not only related to the 3 primary areas of interest, practice, research, and education but also other areas such as marketing, diversity, membership, and technology. It will be difficult if not impossible to cover all the events during this time; however, we will illuminate some of the more important events that took place.

PRACTICE

Under the watchful eyes of Steve McDavitt, PT, MS, Helene Fearon (previous Co-chair), and the Practice Committee, orthopaedic physical therapy practice continues to remain in the forefront of our mission. Encroachment by chiropractors, physicians, and other health care practitioners have kept the Practice Committee extremely busy during the past 5 years. In response to this long-term challenge the Orthopaedic Section linked with APTA, AAOMPT, and Chapters to form the Manual Therapy Legislative Task Force in 1999. An aggressive strategic plan was developed related to the germane legislative, regulatory, and educational issues. Much of the original plan has been completed, but activities do continue. For example, a subgroup of this Task Force is completing a Manipulation Education Resource packet for PT educators who teach the manual therapy content in PT professional degree programs. The produced documents and resources have helped numerous Chapters retain the right to practice manual therapy as we have been trained. The Task Force will continue to be a vigilant ally in providing valuable information and feedback to help states with this most odious transgression.

Physician owned physical therapy services (POPTS) has recently reared its ugly head once again. Physicians hurt by poor reimbursements have looked into again owning physical therapy clinics as a method for financial gain, often at the expense of depriving private practice physical therapists income. The Orthopaedic Section's Practice Committee has joined forces with the Private Practice Section to continue to fight this unfair alliance and to educate therapists about the potential abuse of this arrangement.

RESEARCH

Due to the wise financial planning and a positive stock market during the early and mid 1990s, the Section had the ability to help fund a number of large research initiatives. Many of these initiatives were brought forth by the Foundation for Physical Therapy. During the 5 years, the Section made substantial contributions to help fund a clinical research center (awarded to the University of Pittsburgh) as well as a number of Foundation small grant awards of $40,000 each. The latest large commitment to the Foundation transpired at CSM 1999 in San Antonio when the Orthopaedic Section Board of Directors (BOD) voted to fund the Foundation's Clinical Research Network. The motion adopted by the BOD at CSM 2001 was a donation of $350,000 toward the new Clinical Research Network. The Network grant was ultimately awarded to the University of Southern California. The early roots of the network were established when the Orthopaedic Section Board approved a motion to develop a proposal for the funding of a clinical research center to be considered for submission to the Foundation for Physical Therapy after the 1999 Annual Conference.

The Orthopaedic Section, through the Research Committee previously chaired by Phil McClure, PT, PhD and Jay Irrgang, PT, PhD, and now by Kelly Fitzgerald, PT, PhD, also continues the important and popular program of giving out clinical research grants. The Orthopaedic Section Board of Directors have faithfully and resolutely ensured that this important part of our mission has not been compromised. A number of substantial grants have been given out between 1998 and 2002. Projects that were funded include: 'Validation of a Clinical Prediction Rule for Identifying Patients Likely to Benefit from a Lumbar Stabilization Program' and 'Association Between Impairment and Function in Response to Physical Therapy in Individuals with Patellofemoral Pain Syndrome.' These studies and those from the Foundation projects have improved both the science and practice of orthopaedic physical therapy. In addition, in many cases these grants paved the way for numerous PT researchers to procure funding from other sources.

EDUCATION

Education continues to be an important part of the Orthopaedic Section's mission statement. Keeping orthopaedic physical therapists up to date is a big undertaking. This responsibility has been capably led by Lola Rosenbaum, PT, MHS, OCS and Paul Howard, PT, PhD, Chairs of the Education/Program Committee during this time period, who along with the committee members offered superior CSM programming. This programming excellence would not be possible without the help and cooperation of the Orthopaedic Section's Special Interest Groups, which include: Performing Arts, Foot and Ankle, Occupational Health, Pain Management, and Animal Physical Therapists, and the Education Groups, including Patellofemoral, Manual Therapy, Primary Care, and PTAs.

Also during these 5 years the Section was at the forefront of residency education. Spearheaded by Joe Godges, the Section developed a residency program grant initiative to help offset the application credentialing fee with the hopes that the number of programs would multiply. The Section also assisted in the development of a residency program resource packet designed to help budding residencies get their program off the ground. Section members also participated in the development of the credentialing guidelines for programs and served on the APTA credentialing committee.

PUBLICATIONS

During these 5 years significant change occurred within our refereed publication, the *Journal of Orthopaedic and Sports Physical Therapy (JOSPT)*. The first change was a change in ownership. Initially, the majority interest of the *Journal* was owned by the Orthopaedic Section (70%) with the Sports Section owning the remaining (30%). A change in the Articles of Incorporation in 2001created an equal 50/50 ownership between the Orthopaedic and Sports Sections and the development of a *JOSPT* Board of Directors made up of Orthopaedic and Sports Section representatives and outside members. Prior to this article change the Sections' served an advisory role on the *Journal* Board. The Section's current representatives to the *Journal* Board, Lola Rosenbaum and Gary Smith, have provided the Orthopaedic Section an important voice in the governance of the Journal.

The second change was the move of the *Journal* office from LaCrosse, Wisconsin to Alexandria, Virginia in 2001. This move was primarily aimed at improving the management and growth of the *Journal* since the Alexandria area had a larger publishing market. Another major change was the selection of a new Editor-in-Chief, Guy Simmoneau, PT, PhD who took over for Dr. Rick DiFabio, PT, PhD. We now have a new *JOSPT* staff; a new Editor-in-Chief; a new, expanded editorial board; and a new location. All of this adds up to a very promising future for this valued membership benefit.

Orthopaedic Physical Therapy Practice (OP), the Orthopaedic Section's non-referred magazine, continued to grow during this period under the direction of Editor Susan Appling, and Managing Editor, Sharon Klinski. The scope and depth of articles written by physical therapists continued to improve and enlighten. Articles such as 'Differential Diagnosis of Foot and Heel Pain and Treatment in Runners' and 'Essential Treatment of Selected Forearm Fractures' help give physical therapists and physical therapist assistants a new or innovative look at treatment. Board minutes and membership minutes are published along with information by the Special Interest Groups. A great change regarding *OP* is the recent increase in revenues generated from advertising. Revenues have posted dramatic increases in the last 2 years, and we hope this continues. The success of this increase in advertising revenue is in large part due to the efforts of Linda Calkins, Project Assistant; Sharon Klinski, Managing Editor; and Advertising Assistance.

Sharon Klinski serves as Managing Editor for a number of journals and newsletters published by the Orthopaedic Section including: the *Cardiopulmonary Physical Therapy Journal*, the *Journal of Geriatric Physical Therapy*, the *Journal of Neurology Physical Therapy*, *Oncology Rehabilitation*, the *Section on Women's Health Journal*, *GeriNotes*, *Hand Prints*, and *Highlights*.

Home Study Courses, recently renamed Continuing Physical Therapy Education (CPTE), are an important venue for delivering quality and affordable education to our members and remains our primary nondues revenue mainstay. Carolyn Wadsworth (previous Editor) and Mary Ann Wilmarth, current Editor with Kathy Olson, Managing Editor continue to publish outstanding continuing education materials for physical therapists and physical therapist assistants. Recent courses have included 'Prosthetic and Orthotics,' 'Effective Prevention & Management of Work-related Injuries,' and 'Medical Screening for the Physical Therapist,' to name just a few. As more states require continuing education we hope to reposition ourselves to offer the best in orthopaedic physical therapy education to all physical therapists and physical therapist assistants.

GOVERNANCE

Bylaws are staid rules that help govern an organization. The Orthopaedic Section discovered that its bylaws were somewhat ambiguous in certain areas and as a result made some necessary changes and presented the restated bylaws to the membership for approval in the summer of 2003. The restructuring of our bylaws resulted in ones that were clear and propitious. Few like to review, much less write bylaws; however, with the help of APTA, the Section's bylaws were rewritten to bring them in line with the Delaware corporate law and APTA's bylaws. The bylaws of an organization give rights and privileges to both the majority and minority members of a group so that every one on the Board has a fair and honest "say" in the outcome of Board activity. To further improve the efficient and effective operation of the Section, monthly Board of Director conference calls were implemented. These calls have made the BOD's job much easier.

The change in Section bylaws also stimulated the revision of our policy and procedure document. Most Boards are good at making motions; however, they are often not so good at making sure the new motions don't conflict with ones already in place. Thus, after reviewing the bylaws the Board discovered that many policies and procedures were outdated, incomplete, or confusingly repetitive. Terri DeFlorian, who has been with the Section for 15 years, and Tara Fredrickson, who has been with the Section for 11 years, continue to work hard to harness the abundant energy of a very divergent group of therapists that are spread out across the country—an intimidating and daunting job.

PUBLIC RELATIONS & MEMBERSHIP

Terry Randall and the Public Relations Committee provided Section representation at a number of health professions' conferences educating other professions on physical therapy. During this period the Membership Committee was re-established and led by Michael Wooden. His committee has generated a number of initiatives designed to bring more members into the Section.

WEBSITE

The Orthopaedic Section's web site (www.orthopt.org) has undergone a major evolution over the last 5 years. Our members have seen many changes and will continue to see this site grow and provide even greater information to its visitors. Our web site has been redesigned twice in the last 5 years, each time with increased functionality. Some of the additions that have taken place are: online ordering of home study courses; a bulletin board; offering the Orthopaedic Section's magazine, *Orthopaedic Physical Therapy Practice*, online —both current and archive issues; an online membership directory which includes member's special interests; an area to post job openings and CVs; and a member-only area which informs our members of the many great benefits of belonging to the Orthopaedic Section. Keep an eye on our web site! There are many more changes and improvements ahead!

SPECIAL INTEREST GROUPS AND EDUCATION GROUPS

The Special Interest Groups and Educational Groups, as described previously, remain a very important part of our Education team. These groups do much more than just provide education; they provide an important avenue for physical

therapy professional growth. Currently, two groups—Primary Care and Performing Arts—were given funds to perform a practice analysis. These grants were given in preparation for specialization in their particular area of practice.

SUMMARY

The Orthopaedic Section's mission is to "... be the leading advocate and resource for the practice of Orthopaedic Physical Therapy. The Section will serve its members by fostering quality patient/client care and promoting professional growth through: enhancement of clinical practice, advancement of education, and facilitation of quality research." The growth and activities that occurred from 1998 to 2003 were made possible by the wise decisions made by Section Boards from previous years and by the dedication of dozens of individuals who volunteered their time to the Section during this time period. Future growth will depend upon the continued involvement of hard-working individuals who will link with our outstanding office staff. Also, related to our future, our current financial state is stable thanks to our Treasurer, Joe Godges, PT, DPT, OCS (along with the Finance Committee members: Stuart Platt, Pam White, Steve Clark, and previous Treasurer, Ann Grove). Our office and property in LaCrosse, Wisconsin are debt-free.

The Section and orthopaedic physical therapy practice future is uncertain, but we do know that change is inevitable. We are committed to continue aggressively pursuing the current strategic plan in order to best serve and represent membership.

Remembering Steven J. Rose

Mary Ann Wilmarth, PT, DPT, MS, OCS, MTC, CertMDT

Some people leave more of a lasting impression with their life than others. Steven Joel Rose was one of those memorable people. His legacy lives on in numerous ways and I hope to convey this concept through the following article as a tribute to the late Steven J. Rose, PT, PhD, FAPTA.

There are always many twists and turns throughout one's life, and I found myself in such a crossroad in thinking about writing this tribute for Steven J. Rose. On this 30th Anniversary for the Orthopaedic Section of the APTA, I find myself bridging different parts of the same circle of life. I have been actively involved with the Orthopaedic Section throughout my career. As recently as last year, I sat at meetings in LaCrosse in view of Steven J. Rose's plaques. I would then return to sit at the Parents' Association board meetings with Kimberly Rose, wife of Kevin Rose, Steven's son. We live in the same town and our children attend the same school that is well-known for instilling a deep love of learning within each student, not unlike Steve's philosophy. With all these connections, I felt that it would be an honor to pay tribute to Steven Rose and his legacy during this anniversary time. I spoke with Kevin Rose, Steve's son, and also touched base with Tony Delitto and Dave Sinacore.

Kevin Rose remembers when his father was the Chair of the Physical Therapy Program at SUNY Buffalo. He particularly recalls the special connections with all the students. There were many dinners with people such as David Sinacore and Tony Delitto where the conversations revolved around such topics as research, scientific evidence, diagnoses, and clinical decision-making. These dialogues became the basis for our current immersion with evidence-based practice and outcomes measures. Kevin mentioned that people would often talk about the fact that Steve was "further down the road" exploring unchartered territory and forging new paths for critical thinking and evidence for practice.

According to Dave Sinacore, "Steve touched us all in incalculable ways. From a more personal perspective, immediately upon graduating with a bachelor's degree in PT from SUNY Buffalo, Steve offered me, along with Tony Delitto, our first clinical jobs as staff physical therapists in St Louis. Little did I realize, at that time, that his offer was actually part of his 'plan' to infuse a new PT research initiative at a small, private university in the Midwest. In the years immediately preceding his untimely death, Steve successfully re-launched the same strategic research plan at the University of Miami, FL where to this day at both institutions, clinical research in physical therapy remains a central mission of their academic cultures."

> "It is Steve's tireless energy, scientific insight, and professional leadership that future generations of physical therapists were prematurely deprived of by his death, though his spirit, contributions, and visions for the practice of physical therapy remain for all of us to fulfill and refine."

Dave elaborates that "Steve was the most remarkable of mentors who possessed, what I believe to be some of the most exemplary requisites for that relationship—namely a keen, inquiring intellect, an uncanny clarity of vision for professional development, and an indefatigable work ethic. No matter how late Steve was teaching or working the previous night, he would typically arrive well before 6 a.m. the next morning to begin yet another day of professional tasks. Steve mentored not only by offering sage advice on the clinical practice of physical therapy, but also by modeling, fostering, and supporting every facet of my academic, professional, and scientific development."

"Steve's impact on contemporary issues pertinent to physical therapy such as physical therapy diagnoses, classification of movement-related diagnostic signs and symptoms, evidence-based physical therapy interventions, and clinical decision-making is rooted in the relentless pursuit of the science of physical therapy. According to David, "It is Steve's tireless energy, scientific insight, and professional leadership that future generations of physical therapists were prematurely deprived of by his death, though his spirit, contributions, and visions for the practice of physical therapy remain for all of us to fulfill and refine."

Tony Delitto shares some of his memories of Steve. "You have to remember that for me, Steve was my mentor. Mentoring occurred in just about every imaginable setting, but some of my fondest memories occurred over Chinese dinners. Steve loved Chinese food, and I think he could have had eaten it 3 times a day. The outline of my first published manuscript resulted from notes jotted down on the napkin from a Chinese restaurant in the Central West End of St. Louis."

According to Tony, "Steve knew the best Chinese restaurants in cities all over the country. I don't know how he had the memory for such things, but invariably we would end up with a group in a Chinese restaurant. I can recall some of our best conversations, and some of our best decisions, came from these meetings. Like my decision to forego a lucrative private practice offer and instead pursue a doctoral degree (something my wife reminds me of on a daily basis!), which occurred at a Chinese restaurant off of Olive Boulevard in St. Louis." We all thank you Tony!

"On a more serious note, Steve was a mentor to a number of people who remain close friends. In fact, we affectionately refer to ourselves as the 'Young Turks.' Above all, Steve instilled in us the need to behave as respectable scientists, meaning that we had to expose our practice to the same level of scrutiny as other respected health professions and publish our findings in reputable journals. Standing true to this basic principle would result in respectability as a profession. I learned from Steve that there are no shortcuts to achieving respectability, and I can say without a doubt that many of us have guided our professional behavior with this basic premise in mind."

Kevin Rose worked as a physical therapy aide at a hospital in St. Louis. He enjoyed the experience and the connection with the people there. Although Kevin did not follow in his father's footsteps in the profession of physical therapy, he did as far as Steve's love of learning. The philosophy that Steve had was one of putting forth your best effort.

Kevin states that his father instilled in him the fact that "Whatever you decide to do, you should put in the effort to do your best." This was evident in Steve's life and work and is also paramount to the physical therapy profession. Everybody that came in contact with Steve, whether family, friend, or colleague, wanted to do their best as well and he fostered that feeling with everyone. The evidence for the effectiveness of Steve's philosophy lives on in his children and grandchildren with their critical thinking skills and their love of learning. So too does this same feeling come across in the physical therapy schools and facilities across the country.

Kevin felt that the relationships that his father, Steve, formed with people throughout the country were of the utmost importance. It was actually through these connections that Kevin came to Boston and met his wife, Kimberly. They continue to receive articles concerning Steve and the work that he did. Kevin and his family enjoy seeing and sharing these things with their own children. Kevin was at the dedication of the Steven J. Rose Center for Clinical Research at the University of Miami and he recently took their 3 children to visit the center.

Steve Rose left his mark in both a very personal and professional manner. The physical therapy community as a whole, as well as each of us as individuals, is extremely grateful for his insight, wisdom, and compassion. On behalf of all of us, I say thank you to the legacy that Steve Rose left for us. The physical therapy profession would not be where it is today without Steve's insight.

Kevin knew that his father did a lot of work with physical therapy, traveled and attended meetings, and gave talks. However, as Kevin got older he realized more and more the fact that his father was truly a national presence. It really hit home for him when he saw the tremendous support of people for Steve's funeral. He felt that it was extremely touching to see so many caring individuals there to support his family.

The dialogue regarding the evidence for effectiveness of specific physical therapy techniques may go on, but there is no question as to the evidence for the effectiveness of Steven J. Rose's life and legacy. Learning is a life-long process. Steve instilled that love of learning in those people whose life he touched and there were many, too many to recall here. However, special thanks go to Kevin, Kimberly, Spenser, Griffen, and Cade Rose for sharing their thoughts with all of us for this 30th anniversary issue. We extend our deepest appreciation to the entire Rose family—Carol, Debbie, Lisa, and Kevin. Congratulations, best wishes, and thank you!

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The Pelvic Floor: Functional Anatomy & Applications for Lumbopelvic Stability

Pelvic Floor Pain Step by Step: Evaluation, Education, Exercise • *Kathe Wallace, P.T.*

June 25 - 27, 2004 • Los Angeles, California

Female Pelvic Floor Function, Dysfunction and Treatment - Level I

Kathe Wallace, P.T. and Hollis Herman, M.S., P.T., O.C.S.

March 26 - 28, 2004 • Philadelphia, Pennsylvania

July 30 - August 1, 2004 • Baltimore, Maryland

October 15 - 17, 2004 • Chicago, Illinois

December 2 - 4, 2004 • Las Vegas, Nevada

Female Pelvic Floor Function, Dysfunction and Treatment - Level II

Kathe Wallace, P.T. and Hollis Herman, M.S., P.T., O.C.S.

November 12 - 14, 2004 • Atlanta, Georgia

Pregnancy and Postpartum: Clinical Highlights

Hollis Herman, M.S., P.T., O.C.S.

February 21 - 22, 2004 • Orlando, Florida

June 26 - 27, 2004 • Minneapolis, Minnesota

August 7 - 8, 2004 • San Diego, California

SI Evaluation and Manual Therapy Treatment:

A Rocabado Approach with Pelvic Floor/Transversus Stabilization

Dawn Sandalcidi, P.T., R.C.M.T.

January 17 - 18, 2004 • Atlanta, Georgia

Sept. 11 - 12, 2004 • Newark, New Jersey

Oct. 2 - 3, 2004 • Chicago, Illinois

Nov. 6 - 7, 2004 • Seattle, Washington

Pediatric Incontinence and Pelvic Floor Dysfunction

Dawn Sandalcidi, P.T., R.C.M.T.

May 22 - 23, 2004 • Chicago, Illinois

Rotator Cuff of the Pelvis

Chronic Pelvic Pain and Low Back Pain

Janet A. Hulme, M.A., P.T.

April 23 - 25, 2004 • Las Vegas, Nevada

October 8 - 10, 2004 • Orlando, Florida

Beyond Kegels I: Bladder Health and the Pelvic Muscle Force Field

Beyond Kegels II: Advanced Techniques and Special Populations • *Janet A. Hulme, M.A., P.T.*

Feb. 20 - 22, 2004 • San Diego, California

March 12 - 14, 2004 • Atlanta, Georgia

June 4 - 6, 2004 • Minneapolis, Minnesota

July 9 - 11, 2004
Cincinnati, Ohio

Sept. 10 - 12, 2004
Boston, Massachusetts

Oct. 22 - 24, 2004
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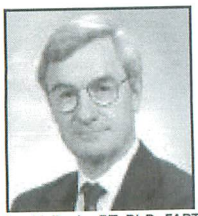

Stanley V. Paris, PT, PhD, FAPTA
President

S1 - Introduction to Spinal Evaluation & Manipulation

40 Hours, 4.0 CEUs (No Prerequisite) — $750

St. Augustine, FL	Paris/Viti	Oct 9 - 13
*Montgomery, AL	Yack	Nov 2 - 6
Pittsburgh, PA	Viti	Nov 7 - 11
Baltimore, MD	Smith	Nov 7 - 11
Orlando, FL	Yack	Dec 3 - 7
Houston, TX	Viti	Dec 10 - 14
2004		
*St. Augustine, FL	Paris/Viti	Jan 11 - 15
Chicago, IL	Yack	Jan 14 - 18
Washington, DC	Smith	Jan 16 - 20
Denver, CO	Yack	Feb 19 - 23
New York City, NY	Yack	Mar 4 - 8
Charlotte, NC	Viti	Mar 11 - 14
Lexington, KY	Lonneman	Apr 21 - 25
Sioux Falls, SD	Yack	Apr 22 - 26
Atlanta, GA	Smith	May 1 - 5
Las Vegas, NV	Yack	May 5 - 9
Amarillo, TX	Viti	May 12 - 16
Springfield, MO	Smith	May 12 - 16
St. Augustine, FL	Paris/Viti	May 19 - 23

E1 - Extremity Evaluation and Manipulation

36 Hours, 3.6 CEUs (No Prerequisite) — $645

Omaha, NE	Turner	Oct 16 - 19
Springfield, MO	Busby	Oct 16 - 19
St. Augustine, FL	Patla	Nov 6 - 9
Dallas, TX	Turner	Nov 13 - 16
2004		
Las Vegas, NV	Turner	Jan 15 - 18
St. Augustine, FL	Patla	Feb 19 - 22
Toledo, OH	Turner	Feb 26 - 29
Boston, MA	Busby	Mar 4 - 7
Baltimore, MD	Busby	Apr 22 - 25
Coral Springs, FL	Turner	Apr 22 - 25
Chicago, IL	Busby	May 6 - 9
LaJolla, CA	Turner	May 20 - 23
Atlanta, GA	Busby	Jun 3 - 6
St. Augustine, FL	Patla	Jun 10 - 13

E2 - Extremity Integration

24 Hours, 2.4 CEUs (Prerequisite E1) — $495

Denver, CO	Varela	Oct 17 - 19
Las Vegas, NV	Varela	Nov 7 - 9
St. Augustine, FL	Patla	Dec 5 - 7
2004		
Knoxville, TN	Varela	Jan 16 - 18
Washington, DC	Varela	Feb 27 - 29
St. Augustine, FL	Patla	Mar 12 - 14
Omaha, NE	Varela	Mar 26 - 28
Las Vegas, NV	Varela	May 14 - 16

Pelvic Floor Dissection

19 Hours, 1.9 CEUs (No Prerequisite) — $495

St. Augustine, FL	Gorniak	Oct 17 - 19
2004		
St. Augustine, FL	Gorniak	Oct 22 - 24

Motor Control & Motor Learning

23 Hours, 2.3 CEUs (No Prerequisite) — $450

2004		
Knoxville, TN	Lowe	Mar 26 - 28

S2 - Advanced Evaluation & Manipulation of Pelvis, Lumbar & Thoracic Spine

27 Hours, 2.7 CEUs (Prerequisite S1) — $495

Las Vegas, NV	Yack	Oct 3 - 5
New Orleans, LA	Yack	Oct 24 - 26
*Orlando, FL	Yack	Nov 16 - 18
2004		
Atlanta, GA	Yack	Jan 30 - Feb 1
Pittsburgh, PA	Irwin	Feb 20 - 22
St. Augustine, FL	Irwin	Mar 26 - 28
Milwaukee, WI	Yack	Apr 9 - 11
Boston, MA	Yack	May 14 - 16
St. Augustine, FL	Irwin	Jun 25 - 27

MF1 - Myofascial Manipulation

24 Hours, 2.4 CEUs (No Prerequisite) — $495

Denver, CO	Cantu	Oct 10 - 12
Las Vegas, NV	Cantu	Nov 7 - 9
Ft. Lauderdale, FL	Grodin	Dec 12 - 14
2004		
St. Augustine, FL	Cantu	Mar 12 - 14
Las Vegas, NV	Grodin	Mar 19 - 21
Beverly, MA	Cantu	Apr 23 - 25
Virginia Beach, VA	Cantu	May 14 - 16

CERTIFICATION WEEK Preparation and Examination

36 Hours, 3.2 CEUs
(Prerequisites for each Certification vary) — $825

St. Augustine, FL		Oct 6 - 11
2004		
St. Augustine, FL		Jan 5 - 10
St. Augustine, FL		May 10 - 15
St. Augustine, FL		Sep 13 - 18
St. Augustine, FL		Oct 11 - 16

Basic Cranio-Facial

20 Hours, 2.0 CEUs (No Prerequisite) — $465

2004		
LaJolla, CA	Rocabado	Jul 17 - 19
Las Vegas, NV	Rocabado	Jul 22 - 24

Intermediate Cranio-Facial

20 Hours, 2.0 CEUs (Prerequisite Basic Cranio-Facial available online) — $465

2004		
St. Augustine, FL	Rocabado	Feb 26 - 28

S3 - Advanced Evaluation & Manipulation of the Cranio Facial, Cervical & Upper Thoracic Spine

32 Hours, 3.2 CEUs (Prerequisite S1) — $695

Ft. Myers, FL	Rot	Nov 6 - 9
*Virginia Beach, VA	Smith	Dec 14 - 17
2004		
St. Augustine, FL	Paris/Rot	Jan 17 - 20
LaJolla, CA	Rot	Feb 19 - 22
Detroit, MI	Rot	Mar 25 - 28
St. Augustine, FL	Paris/Rot	May 6 - 9
Atlanta, GA	Smith	Jun 25 - 28
Milwaukee, WI	Rot	Jul 22 - 25
Las Vegas, NV	Rot	Aug 26 - 29

S4 - Functional Analysis & Management of Lumbo-Pelvic-Hip Complex

16 Hours, 1.6 CEUs (Prerequisite S1) — $465

Ft. Lauderdale, FL	Varela	Oct 4 - 5
St. Augustine, FL	Varela	Oct 25 - 26
Baltimore, MD	Nyberg	Nov 8 - 9
Atlanta, GA	Nyberg	Dec 6 - 7
2004		
St. Augustine, FL	Varela	Jan 24 - 25
Baltimore, MD	Varela	Mar 20 - 21
Atlanta, GA	Nyberg	Apr 24 - 25
Washington, DC	Nyberg	May 1 - 2
St. Augustine, FL	Varela	Jun 5 - 6
New York City, NY	Nyberg	Jun 12 - 13
Las Vegas, NV	Varela	Jul 7 - 11

Spinal Instability - Whole Spine Stabilization

7 Hours, .7 CEUs (No Prerequisite) — $195

Los Angeles, CA	Paris	Oct 2

Advanced Cranio-Facial

20 Hours, 2.0 CEUs (Prerequisite Intermediate Cranio-Facial) — $465

2004		
St. Augustine, FL	Rocabado	Feb 29 - Mar 2

State of the Art Cranio-Facial

20 Hours, 2.0 CEUs (Prerequisite Advanced Cranio Facial, S1 & S3 Seminars) — $465

2004		
St. Augustine, FL	Rocabado	Mar 3 - 5

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Ortho 10-03

Orthopaedic Clinical Specialist—Looking Back on How We Got Here

Rick Ritter, PT, MA, OCS

It is hard to imagine that there is nearly a generation of physical therapists out there for whom clinical specialization has become the 'norm.' Since that first examination in 1989 there have been colleagues hard at work refining the process, the content, and the integrity of the Orthopaedic Clinical Specialist (OCS) credential. My involvement really kicked into high gear in June 1988 when I was named to the Orthopaedic Specialty Council (OSC). But the story really goes back to the early 1970s when this concept was first discussed. Forward thinking individuals, including Orthopaedic Section Past President Stan Paris, proposed the notion of a process by which a physical therapist could become recognized as practicing at an advanced clinical level by the American Physical Therapy Association (APTA).

Through action by the APTA House of Delegates, the American Board of Physical Therapy Specialties (ABPTS) was established in 1978. While separate from the APTA and accountable to the House of Delegates, it was charged with oversight that included ensuring the reliability and validity of the specialization process. The first Orthopaedic Specialty Council was established in 1980 for the purpose of creating an application and examination process by which physical therapists with advanced clinical competence could be recognized. Marilyn Anderson, Barbara Stevens, and Carolyn Wadsworth developed our first Competency Document between 1980 and 1983 with contributions by others. The test specifications and competency document were accepted by ABPTS after continued hard work by Betty Sindelar, Richard Bolling, and Eileen Vollowiz. However, those dedicated individuals had some major struggles during the developmental years. At the center of the struggle was the desire for a practical component for the examination. It became clear that reaching agreement on elements of a practical examination that would have the reliability and validity required by ABPTS would not be possible given the time and available resources. With deadlines for the examination based on the original competency document fast approaching, the decision was made that the practical examination had to be abandoned. Understandably this decision caused a great deal of disappointment, and the members of the Orthopaedic Specialty Council at the time decided to resign.

In June of 1988 the Orthopaedic Section appointed a new Orthopaedic Specialty Council. Joe McColloch, Rick Ritter, and Susan Stralka agreed to accept the challenge of preparing the examination within a tight (3 month) timeline. There were literally hundreds of items that had been collected by previous Council members and from many different item writers. However, each item had to be edited for format, the content referenced, and both the correct answer and incorrect answers referenced. Truly, we each had what seemed like a mountain of paper that we worked through to get test items that were acceptable in both content and format. The application criteria required to sit for the examination were approved by ABPTS in 1988, and the first examination was scheduled for June 1989. Construction of the examination was an oddly interesting but torturous process. Working with the testing agency editor, we constructed an examination that matched the blueprint reflecting the knowledge areas and practice dimensions established in the competency document. It was clear to us that accurately defining advanced clinical practice and assuring that the examination reflected this practice would be an ongoing process. However, we were elated that the first examination was prepared and ready to administer.

Those who applied for the examination in the early years remember a rather lengthy and detailed application process. No one was more aware of the amount of paperwork required for those first few years than those of us who had to review each application. As the examination was administered a few times and we began to have more confidence in the examination's ability to distinguish the advanced practitioner, we refined the application process. We were able to incorporate test items dealing with research into the examination. We found that the letters of recommendation were not a determining element, and they were eliminated. But there was plenty of work ahead as it was again time to revalidate the clinical competency document.

Before I go on, I would like to spend a little time on the issue of the practical examination because the Council had many long discussions about the possibility of including a practical examination. While the concept seems so intuitively right, the ability to establish a valid and reliable testing instrument for an examination at this level is next to impossible. I say next to impossible, because it may be possible. Of course, given unlimited time and especially unlimited money anything can be done—-or so it would seem. When we took a good look at just what it was a practical examination would do, it became clear that an 'episodic evaluation of skill' (a practical examination), in no meaningful way would establish the clinical reasoning process that is at the heart of advanced practice. Other specialty councils had some of the same concerns about the practical examination. The idea that emerged was that evaluation of skill should take place over time rather than in an 'episode,' and the model we had for that was the residency program. Residency programs in both sports and orthopaedic physical therapy were emerging at that time, with the Kaiser-Hayward program leading the way. While we were not successful in establishing a mechanism for a direct relationship between a residency program and the OCS examination, the idea is still considered something that may be accomplished in the future. Application to sit for the exam has been streamlined for residency graduates as shown at www.apta.org/education/specialist/abptscert.

The policy of the ABPTS required that descriptions of specialty practice be revalidated or revised at least every 10 years to ensure that they reflect the most up-to-date specialty practice. By 1992 the OSC members, Rick Ritter, Mary Milidonis, and Mary Ann Sweeney were faced with the need for revalidation of the competency document. Mary Milidonis developed a schedule with timelines that would guide us through the task. There are many reasons for revalidating a competency document that deals with test construction and administration. However, the most compelling reason is easily observed by clinicians who know the changes that have occurred in practice over a 10-year period. Among our goals for the project were to establish clear linkages between the

competency document and the examination, and make the document more user-friendly. In developing the 'practice relatedness' of the examination we wanted to test what we do and what we need to know in order to do it. Standing on the shoulders of the previous work that had been done, the new Description of Advanced Clinical Practice (DACP) document emerged. That DACP has been used by item writers for their work, OSC members in test construction, and applicants as a way of evaluating their own current practice. However, just as with previous documents, this DACP also had a limited life span.

Jean Bryan, Bob Johnson, Robert Landel, and Nancy Henderson had primary responsibility for developing the current 2001 Orthopaedic Physical Therapy Description of Specialty Practice (DSP). As with previous descriptions of practice, this document is based on results of an extensive survey of over 1500 orthopaedic specialists. Again, revisions were driven by changes in practice, primarily the *Guide to Physical Therapist Practice* and evidence based practice. The current document is in *Guide* language and includes case scenarios and sample questions with explanations to show linkages between knowledge areas and practice dimensions, using evidence based material whenever possible.

My experience with the specialization process has been one of the peak learning opportunities of my professional career. Any of the tough times were far outweighed by the experience of working with such outstanding individuals throughout my time on the Specialty Council. After the prescribed time away from the test development and decision-making, I was finally eligible to sit for the OCS examination. Believe me it was pressure packed. I agonized pretty much every day during preparation, the examination, and in the endless weeks following the examination waiting for my results. Being able to walk across the stage in the recognition ceremony at Combined Sections Meeting 2001 brought the process to completion for me. It was a moment of great personal satisfaction and accomplishment. I believe in the concept and continue to promote participation in and refinement of the recognition of advanced clinical practice.

HISTORICAL FACTS

There are 2563 board certified orthopaedic clinical specialists (OCS) to date.

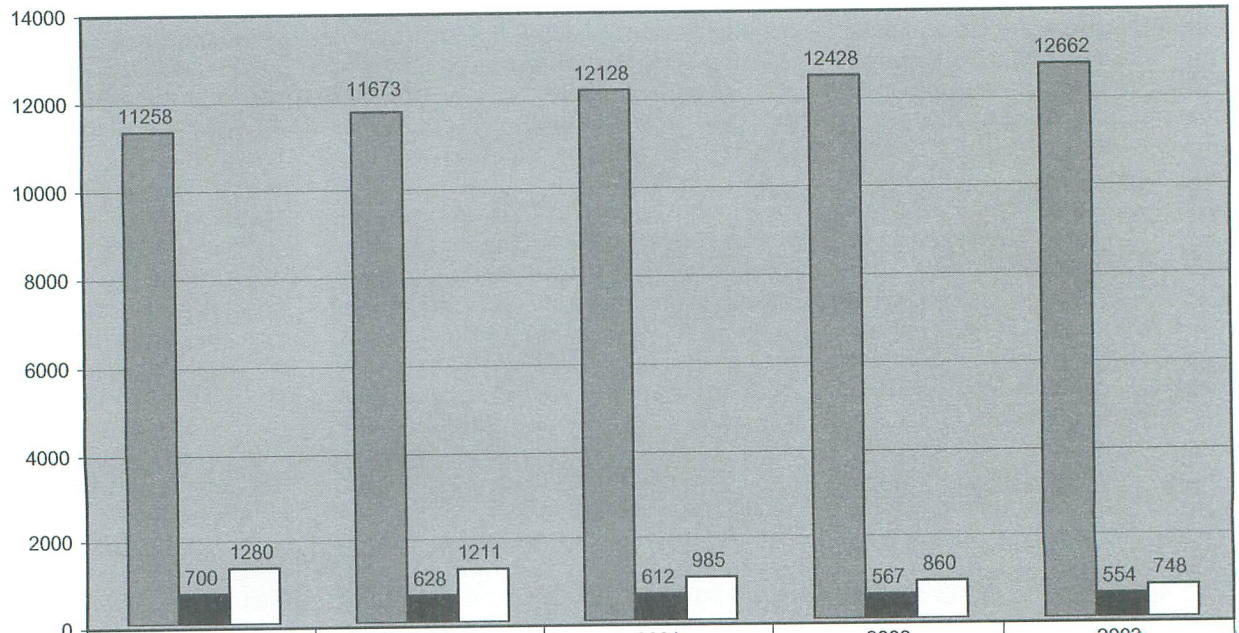
There are 274 people who have been recertified.

There were 26 OCSs in the first class in 1989 to include:

Steven C Allen, PT, MS, OCS
John M Barbis, PT, MA, OCS
Paul F Beattie, PT, PhD, OCS
Mark Beissel, PT, OCS
Anne Campbell, PT, OCS, FAAOMPT
David Clegg, PT, MA, OCS
Martha K Frame, PT, MBA, OCS
Joseph Godges, PT, MA, OCS
Brenda L. Greene, PT, PhD, OCS
George F Hamilton, PT, MS, OCS
Patricia S Hartman, PT, MS, OCS
Michael E Keenum, PT
Randall Scott Kusunose, PT, OCS
Howard W Makofsky, PT, DPT, OCS
Lynn N McKinnis, PT, OCS
Mary Milidonis, PT, PhD
Ann E Porter-Hoke, PT, OCS
John Risse, PT, OCS
Elaine Rosen, PT, DHSc, OCS, FAAO
Roslyn Sofer, PT, OCS
Janet A. Tenhula, PT, MHS, OCS
Kent E Timm, PT, PhD, OCS, SCS
Stephen R Weinberger, PT, OCS
Bruce Wilk, PT, OCS
Russell M Woodman, PT, DPT, FSOM, OCS
Mary K Zane, PT, MEd, OCS

NOTE: Thank you to Jean Bryan Coe, PT, PhD, OCS for her assistance and feedback in writing this article.

Orthopaedic Section Membership Totals 1999-2003



	1999	2000	2001	2002	2003
PT MEMBERS	11258	11673	12128	12428	12662
PTA MEMBERS	700	628	612	567	554
STUDENTS	1280	1211	985	860	748

Some Things Remain the Same

In reflecting our on our 30-year anniversary, some issues resurface. The following articles are reprinted from prior issues of *OP* related to such issues. One relates to professional practice and the other relates to POPTS.

Referral Pad Indictment

Publications Committee Chair Commentary. *Orthop Phys Ther Pract.* 1991;3(1):4.

Are physical therapists practicing an elaborate game of avoidance by refusing to select the treatment intervention most appropriate for the patient? A glance at your current referral pad will reveal if you are ready to accept full accountability for your practice. Historically, the selection of physical therapy services was based primarily on the prescription of treatment by the referring medical practitioner. This has led to the widespread use of the check off type of referral pad so frequently seen in physical therapy clinics (Figure 1).

The check off type of referral pad implies that either the physical therapist does not know what the most effective plan of treatment should be or is not willing to take responsibility for clinical decision making. Consequently, the check off type of referral pad reinforces the widespread ignorance that many referring medical practitioners have of our capabilities. The use of the check off referral pad contradicts our public relations campaign for autonomy and is a striking indictment of our complacency.

Our system of education and training in physical therapy equips us to determine the nature and duration of the treatment program for the patient. Consequently, we need to adopt a referral pad style that reflects our unique knowledge of appropriate, effective, and efficient patient care management (Figure 2).

By ascertaining referral information (Figure 2) as opposed to asking the referring medical practitioner to determine the nature, frequency, and duration of the treatment (Figure 1) physical therapists are accepting full responsibility for their decisions and behaviors. We must not turn our backs on our commitment to uphold our profession.

Of course, the referring medical practitioner has been happy to indulge us by filling out the check off referral pad. However, we are in this together—patient, referring medical practitioner, and physical therapist—and we must assume the responsibility that comes with the title Physical Therapist.

John M. Medeiros, PT, PhD

Patient Name _____

Diagnosis or Impression _____

- ❑ Evaluate & Treat
- ❑ Exercise
- ❑ Ultrasound
- ❑ Phonophoresis
- ❑ High Voltage Galvanic Stimulation
- ❑ Electrical Muscle Stimulation
- ❑ Iontophoresis
- ❑ TENS
- ❑ Biofeedback
- ❑ Hydrocollator Hot Pack
- ❑ Traction
- ❑ Whirlpool
- ❑ Massage
- ❑ Cryotherapy
- ❑ Low Back Rehabilitation
- ❑ Back School
- ❑ Mobilization
- ❑ Ambulation Training
- ❑ Postural Training
- ❑ Home Instruction

Treatment Objectives/Goals

Frequency/Duration

_____ Physician Signature

_____ Date

Figure 1. Check off type of referral pad.

REFERRAL INFORMATION

Patient/s Name: _____ Date: _____

Diagnosis/Chief Complaint: _____

Lab/X-ray Findings: _____

Precautions/Comments: _____

Date of Return Appointment with Physician: _____

Physician Signature: _____

Figure 2. Referral information format.

Has it Really Come to This?

Editor's Note. *Orthop Phys Ther Pract.* 1994;6(4):4.

Not long ago I saw something that really disturbed me. While reviewing charts for a local private practice, the marketing director approached me and asked me to comment on the newspaper ad he was holding. The ad, placed in a major metropolitan daily, promoted the opening of the practices' newest office. Here, in part with the names changed and emphasis added, is what the ad said:

NEW *VENTURE* IN HEALTH CARE
ABC REHAB CENTER
is pleased to announce a Physical Therapy & Orthopaedic Physician office *venture* with XYZ ORTHOPAEDICS
The Area's finest, most highly-qualified Orthopaedic surgeons specializing in joint replacement, sports injuries and other general Orthopaedic conditions
address
Accepting New Patients at (phone)

I was confused. This particular practice is therapist-owned and takes pride in that fact. I asked the marketing director if he was looking for trouble. He told me that he had not placed the ad. So, I asked him why he would allow the orthopaedic surgeons to place an ad like that. He assured me that they had not placed the ad either. I stared incredulously as he informed me that an unknown person had paid cash to run the ad. Had we

been in Hollywood, perhaps that little cartoon light bulb would have appeared over my head at that instant. Ostensibly, this is a normal advertisement. Only a physical therapist or another health care practitioner would object to the venture language—especially in Ohio, where referral for profit has been statutorily prohibited.

Who was this unidentified person willing to spend cash to impugn the reputation of a new physical therapy practice? Logic dictates that it was a competing therapist and hence my questions...*has it really come to this?* Are there physical therapists who are that cutthroat? Are readers going to comment on my Ohio naiveté? I await you comments, but I think I'd rather tell the story and move on. Certainly, there are bigger professional fish to fry. We are faced with a number of issues that may redefine how we practice within the next five to ten years. The old adage of "United we stand and divided we fall" seems more than appropriate. So if there are other battles left to fight. Let's get on with them!

Jonathan M. Cooperman, PT, MS, JD

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Julie M. Fritz, PT, PhD, ATC — Main Author
Stephen Z. George, PT, PhD — Coauthor
Anthony Delitto, PT, PhD, FAPTA — Coauthor

The Role of Fear-avoidance Beliefs in Acute Low Back Pain: Relationships with Current and Future Disability and Work Status. *Pain*. 2002;94:7-15.

2002

Dan Riddle, PT, PhD — Main author
Kang Lee, PT, MS — Coauthor
Paul Stratford, PT, MSc — Coauthor

Use of the SF-36 and SF-12 Health Status Measures: A Quantitative Comparison for Groups Versus Individual Patients. *Medical Care*. 2001;38(8): 867-878.

2001

Gail Deyle, MPT, OCS, FAAOMPT — Main author
Nancy Henderson, PT, PhD, OCS — Coauthor
Robert Matekel, PT — Coauthor
Matthew Garber, PT, DSc, OCS, FAAOMPT — Coauthor
Stephen Allison, PT, PhD, ECS — Coauthor

Effectiveness of Manual Physical Therapy and Exercise in Osteoarthritis of the Knee: A Randomized, Controlled Trial. *Ann Intern Med.* 2000;132 (3);173-181.

2000

Mark Werneke, PT, MS, Dip, MDT — Main author
Dennis Hart, PT, PhD — Coauthor
David Cook, BS, RN — Coauthor

A Descriptive Study of the Centralization Phenomenon. *Spine*. 1999;24(7).

1999

Christopher Powers, PT, PhD — Main author
Robert Landel, DPT, OCS — Coauthor
Tamara Sosnick, MPT — Coauthor
Janet Kirby, MPT, ATC — Coauthor
Ken Mengel, MPT — Coauthor
Andrea Cheney, MPT — Coauthor
Jacquelin Perry, MD — Coauthor

The Effects of Patellar Taping on Stride Characteristics and Joint Motion in Subjects with Patellofemoral Pain. *J Orthop Sports Phys Ther.* 1997;26(6).

1998

Diane U. Jette, PT, DSc — Main author
Allen M. Jette, PT, PhD — Coauthor

Physical Therapy and Health Outcomes in Patients with Spine Impairments. *Phys Ther*. September 1996.

1997

Richard P. Di Fabio, PT, PhD

Efficacy of Comprehensive Rehabilitation Programs and Back School for Patients with Low Back Pain: A Meta-Analysis. *Phys Ther*. October 1995.

1996

Lynn Snyder-Mackler, PT, ScD — Main author
Susan W. Stralka, PT — Coauthor
Sherri L. Bailey, PT — Coauthor
Anthony Delitto, PT, PhD — Coauthor

Strength of the Quadriceps Femoris Muscle and Functional Recovery After Reconstruction of the Anterior Cruciate Ligament a Prospective Randomized Clinical Trail of Electrical Stimulation. *J Bone Joint Surg*. August 1995.

1995

Karen W. Hayes, PT, PhD — Main author
Cheryl Petersen, PT — Coauthor
Judith Falconer, PhD, OTR/L — Coauthor

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Richard W. Bowling, PT — Coauthor
Janet A. Tenhula, PT, OCS — Coauthor
Richard E Erhard, DC, PT — Coauthor
Michael T. Cibulka, PT, OCS — Coauthor

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Scott D. Minor, PT, PhD — Coauthor

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Shane Schulthies, PT, PhD — Coauthor

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Gary Soderberg, PT — Coauthor
Thomas M. Cook, PT, PhD — Coauthor

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AAOMPT 2004 - FIRST CALL FOR ABSTRACTS

The 10th Annual Conference of the American Academy of Orthopaedic Manual Physical Therapists will be held **October 22-24, 2004 (Seelbach Hilton in Louisville, KY).** Interested individuals are invited to submit abstracts for presentation in slide or poster format. The AAOMPT research committee chairman must receive the abstract by **June 1, 2004**. Abstracts received after this date will be returned. You will be notified of the acceptance/rejection of your abstract in July of 2004. If you have any questions call the research committee chairman at (828)-227-2126 or email at: **twatson@wcu.edu**. For additional organization information, check out our website, www.*aaompt.org*.

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

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

SUBMISSION FORMAT. The format for the submitted abstracts is as follows:

The abstract must be submitted by email in MS Word format to the research committee chairman (**twatson@wcu.edu**). The abstract should fit on one page with a one-inch margin all around. The text should be typed as one continuous paragraph. Type the title of the research in ALL CAPS at the top of the page followed by the authors' names. Immediately following the names, type the institution, city, and state where the research was done. Please include a current email address where you can be contacted.

PRESENTATION. The presentation of the accepted research will be in either a slide or poster session. The slide session will be limited to 10 minutes followed by a 5-minute discussion; this session will be primarily for research reports and randomized clinical trials. The poster session will include a viewing and question answer period and will be primarily for case report/series.

RESEARCH PRESENTATION AWARD. The research platform presentation deemed of the highest quality of those presented at the annual conference will be awarded the AAOMPT Excellence in Research Award.

Todd Watson, DPT, OCS, FAAOMPT • Western Carolina University • Cullowhee, NC 28723 • twatson@wcu.edu

Book Reviews

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

LaRaus S. *Interactive Wound Care: A CD-ROM for Health Professionals*. 2003, Slack, Inc., Thorofare, NJ. System requirements: PC: Pentium I or higher; Windows 95 or later; 64MB RAM; 30MB hard disk storage; 1MB SBGA video card; 800 x 600 monitor resolution; Quicktime 5.0 for Windows (included). Macintosh: Power PC or above; Mac OS version 8.6 or later; 64MB RAM; 30MB hard disk storage; 800 x 600 monitor resolution; Quicktime 5.0 for Macintosh (included).

Interactive Wound Care CD-ROM for Health Care Professionals is designed to teach the user the basic principles of wound management. The CD-ROM format provides context material for the visual learner, while providing an interactive experience for the kinetic learner through the use of audio, photos, animation, and videos.

The CD-ROM is divided into 9 components: skin anatomy, stages of wound healing, examination, evaluation, debridement, dressings, interventions, diabetic evaluation, and nutrition. An intervention section provides the user with an understanding of debridement, dressing characteristics, and modality section. A resource section provides the user with information on dressing companies, modality companies, associations, and referenced publications.

The section on basic skin anatomy was a good introduction because of the photos and accompanying audio. It would have been helpful to include neurological and biochemical pathways as it relates to the skin. This background is very essential with the recent implication of these pathways as mechanisms of why diabetic ulcers may not heal as quickly or not heal at all.

The basic stages of wound healing also were well illustrated. The audio and visual portions interacted well with the text. LaRaus alludes later to the evaluation of a person with diabetes with a wound. It would have been helpful to interact with stages of wound healing in the diabetic and how this is different than the proposed stages.

The evaluation and examination section was very good. LaRaus outlines a thorough evaluation and examination complete with appropriate goal writing. This section was very helpful, as clinicians have experienced denials for payment from insurance companies secondary to unclear goals. LaRaus gave good examples but it would have been helpful to set goals based on current healing rates of wounds, for both diabetic and nondiabetic patients. The user could then look at the expected healing rates and their patients healing rate and make changes in the intervention as necessary. The examination section was good for specific wounds with a dedicated section on a diabetic evaluation.

Debridement, both nonselective and selective was very good, especially for students and clinicians new to the area of wounds. This section is very descriptive with indications and contraindications followed by a video to demonstrate the techniques. The same concept of debridement also is evident with the dressings section. With an array of dressings used for wounds, LaRaus covers 12 commonly used dressings complete with pictures, indications, contraindications, and advantages.

Nutrition is an essential component for wound care and LaRaus does a good job describing an assessment, nutritional needs, and nutritional therapy. This is performed using a nutritional screen that identifies those patients at high nutritional risk. Appropriate referrals can be made if high risk is detected. This section also describes blood lab work that is helpful when looking at wounds that are not healing well.

Finally, interventions were described in an interactive style. Each intervention had a detailed explanation followed by physiologic effects, indications, contraindications, and protocols. A video was interactive with the text to display a set up, eg, electrical stimulation. One problem I had with this section was the physiologic effects. The assumption is that these written physiologic effects have been shown to be the mechanism for wound healing. For example, electrical stimulation is said to assist with blood flow and provide an appropriate and adequate electrical stimulation to the wound bed. The references provided indicate that these mechanisms are proposed mechanisms. To claim these physiologic effects with electrical stimulation would be contrary to the current literature.

This CD-ROM is indeed interactive, easy to navigate, and offers a tremendous amount of ready information. I would recommend the CD-ROM to students and clinicians entering the field of wound care. Because of the changing nature of this field with interventions and research, I would not recommend it for seasoned professionals. It may be a nice adjunct to the current literature regarding wound care, diabetics, and physiologic effects of interventions.

Daryl Lawson, PT, MPT

Barber FA, Fischer SP. *Surgical Techniques for the Shoulder and Elbow*. New York, NY: Thieme; 2003, 225 pp., illus.

This is well-organized text providing information on diagnosis, treatment, and surgical procedures for common shoulder and elbow problems. The book is divided into 2 sections. The first 38 chapters are written about the shoulder, and the remaining 15 chapters are written about the elbow. The book serves as a convenient reference for a review of surgical procedures and is written by respected physicians in their areas of expertise.

The chapters in each section are organized by anatomic structure and pathology. The first chapter in the shoulder section discusses shoulder arthroscopy portals. The second through eleventh chapters discuss acromioclavicular separations and dislocations, acromioclavicular joint resections, subacromial decompressions, and symptomatic os acromiale. The next 6 chapters provide information on biomechanics of rotator cuff repairs and the various procedures. Later chapters discuss the treatment of biceps tendon issues, shoulder instability (anterior, posterior, and multidirectional), and adhesive capsulitis. There is a single chapter on the rehabilitation of shoulders, which discusses general rehabilitation guidelines, scapular mechanics, and functional rehabilitation.

The first chapter in the elbow section discusses arthroscopic approaches to the elbow. The subsequent chapters discuss

debridement and loose body removal, treatment of arthrofibrosis, radial head and olecranon fractures, and lateral epicondyle release and repair. Later chapters review tendon avulsions, instabilities, and ulnar nerve transpositions. Individual chapters intermittently discuss postoperative rehabilitation.

This book is an excellent, easy to follow text which reviews surgical techniques, indications for surgery, contraindications, physical findings, diagnostic test results, and postoperative care and rehabilitation. This text is not meant to provide a therapist with a comprehensive resource for postoperative rehabilitation. But it is an excellent reference book for the physical therapist for a quick review of common shoulder and elbow problems and surgical procedures.

Sylvia Mehl, PT, OCS

Makofsky HW. *Spinal Manual Therapy: An Introduction to Soft Tissue Mobilization, Spinal Manipulation, Therapeutic and Home Exercises.* Thorofare, NJ: Slack, Inc; 2003, 253 pp., illus.

This textbook focuses on the examination and treatment of cervical, scapulothoracic, lumbar, pelvic girdle, and temporomandibular joint dysfunctions. The author's stated target audience is the physical therapist student who is learning orthopaedic manual therapy, or the recent graduate.

The initial section consists of covering the basic principles behind spinal manual therapy including indications and contraindications. Spinal biomechanics and barriers to motion are explained clearly with ample illustrations and graphs. McKenzie's postural, dysfunction, and derangement syndromes also are explained.

The next 5 sections cover the examination and treatment of the cervical spine, scapulothoracic region, lumbar spine, pelvic girdle, and temporomandibular joint. Each region's examination section follows a consistent scheme where first, examination of the specific area is presented. Next, treatments using multiple, specific soft tissue mobilization and manipulation techniques are explained. Exercise recommendations finish each chapter. The exercises are balanced between specific stretches, self-mobilizations, strengthening, and muscle retraining. There are numerous pictures with models depicting each of the various assessment and treatment procedures throughout the text. Anatomical drawings or spines accompany the descriptions as well. Lifting techniques are presented.

There is a special chapter entitled *The Role of the Cervical Spine in Headaches and Dizziness* that explains the interrelationships between these unique anatomical structures. A multidisciplinary approach is presented for the complex patient. Testing for cervicogenic dizziness is done by the Fritz-Ritson test and it is demonstrated using a model.

A chapter is reserved to discuss the latest evidence to support manual therapy for the spine and exercise. This is in addition to complete references and bibliography listings after each section. The 15 studies were published from 1981 to 2001. The results are presented and discussed by the author. The final chapter presents multiple case studies that are followed by multiple-choice questions. This gives the reader an opportunity to apply the material in the book and review any specific questions.

One of the strengths of this book is the eclectic approach to treating these patients. Various manipulation and soft tissue techniques are demonstrated. The exercises are clearly shown and do not require the patient to use any specific high-cost equipment. I highly recommend this book for any therapist in an orthopaedic setting. While the book is intended for students or new graduates, experienced clinicians would also benefit from adding this book to their library because of its clear, evidence-based approach.

Jeff Yaver, PT

Nolan M. *Clinical Applications of Human Anatomy: A Laboratory Guide.* Thorofare, NJ: SLACK Inc.; 2003, 112 pp.

The primary goal of *Clinical Application of Human Anatomy: A Laboratory Guide* is to provide students with a method to integrate basic human anatomy constructs with real life clinical applications. The author is a professor of anatomy and applied neuroscience.

The guide is divided into three main anatomical sections: Limbs and Back, Thorax and Abdomen, and Head and Neck. Each section is further divided into chapters. The chapters present review questions and guided inspection and palpation of specific anatomy. The text contains many fill in the blank and short answer questions for students to self assess current knowledge of muscles, joints, vasculature and peripheral nerves. The chapters guide students through the following areas: shoulder girdle and upper limb, hip and lower limb, back, thorax, lungs and pleura, heart, abdomen, head and face, neck, mouth, eye, and ear. Appendix A of the text provides an answer key to all the questions.

The author recommends that students use the manual for small group activities. Emphasis of the exercises is the use of touch and investigation techniques similar to evaluation techniques to help bridge the gap between traditional anatomy instruction and clinical application of such constructs. The text contains no pictures or specific references to other anatomical texts. The author has done this to keep the cost of publishing to a minimum and recommends other sources to be used in conjunction with this guide.

Overall, I would highly recommend this laboratory guide to any physical therapist student or any health professional studying human anatomy. The laboratory guide exercises could also be used as review for experienced clinicians. Even though the text does not have illustrations and photographs, there are many adequate texts and software anatomy applications that could be used in conjunction with the laboratory guide.

Timothy J. McMahon, MPT, OCS

Stahelli LT. *Fundamentals of Pediatric Orthopedics, 3rd ed.* Philadelphia, Pa: Lippincott Williams & Wilkins; 2003, 192 pp., illus.

This is a textbook written for the primary care physician to provide a basic reference for children's problems. The author has written a second text titled, *Practice of Pediatric Orthopedics,* which was produced for the orthopedic surgeon. Some of the content of this second text was included in the third edition of the *Fundamentals of Pediatric Orthopedics.*

The textbook consists of fifteen chapters. The first chapter describes normal and abnormal growth of the child from gamete and early embryo to the adolescent. Chapter two reviews evaluation of the child and chapter three discusses management. The next six chapters discuss individual joints and their pathologies as follows: lower limb, foot, knee and tibia, hip, spine and pelvis, and upper

limb. Trauma, sports injuries, infections and tumors are the subsequent chapters. Lastly, the final chapter reviews parent education and reference material that can be copied for parents (permitted by the author). An index is included to assist with rapid reference of disorders.

This text can be used as a basic review of childhood orthopedic problems. It is not a good reference for thorough discussion of treatment, prognosis, disease, dysfunction, or problem. It does provide excellent illustrations in color, which are often located on the same page as the written discussion. I recommend this text to those therapists that rarely treat pediatric patients as to provide a simple reference book for review.

Sylvia Mehl, PT, OCS

Snyder SJ. *Shoulder Arthroscopy, 2nd ed.* 2003, Lippincott Williams & Wilkins, Philadelphia. 303 pp., illus., with accompanying DVD.

The author of this monograph, Stephen J. Snyder MD, is described in the Foreword as a "master teacher of the art and science of arthroscopic surgery" who has "traversed the globe instructing surgeons in shoulder arthroscopy techniques." The primary audience for this book is surgeons who perform arthroscopic procedures for the shoulder. In this second edition, Dr. Snyder has rewritten most of the chapters and added additional topics on adhesive capsulitis, multidirectional instability, subscapularis tendon, basic arthroscopic skills, knot tying and ganglion cysts.

The first chapter addresses learning shoulder arthroscopy. There are lists of recommended textbooks, journals, and video media. Computer and video stations that simulate shoulder arthroscopy are described, including a virtual-reality arthroscopy simulator. There is also information on educational courses with cadaver labs and Internet learning. Chapter 2 describes the operating room setup for shoulder arthroscopy. Chapter 3 discusses diagnostic arthroscopy of the shoulder, including normal anatomy and variations. A 15-point anatomy review of the glenohumeral joint is highlighted by full-color photographs of arthroscopic techniques and arthroscopic views of shoulder anatomy, supplemented by tricolor drawings.

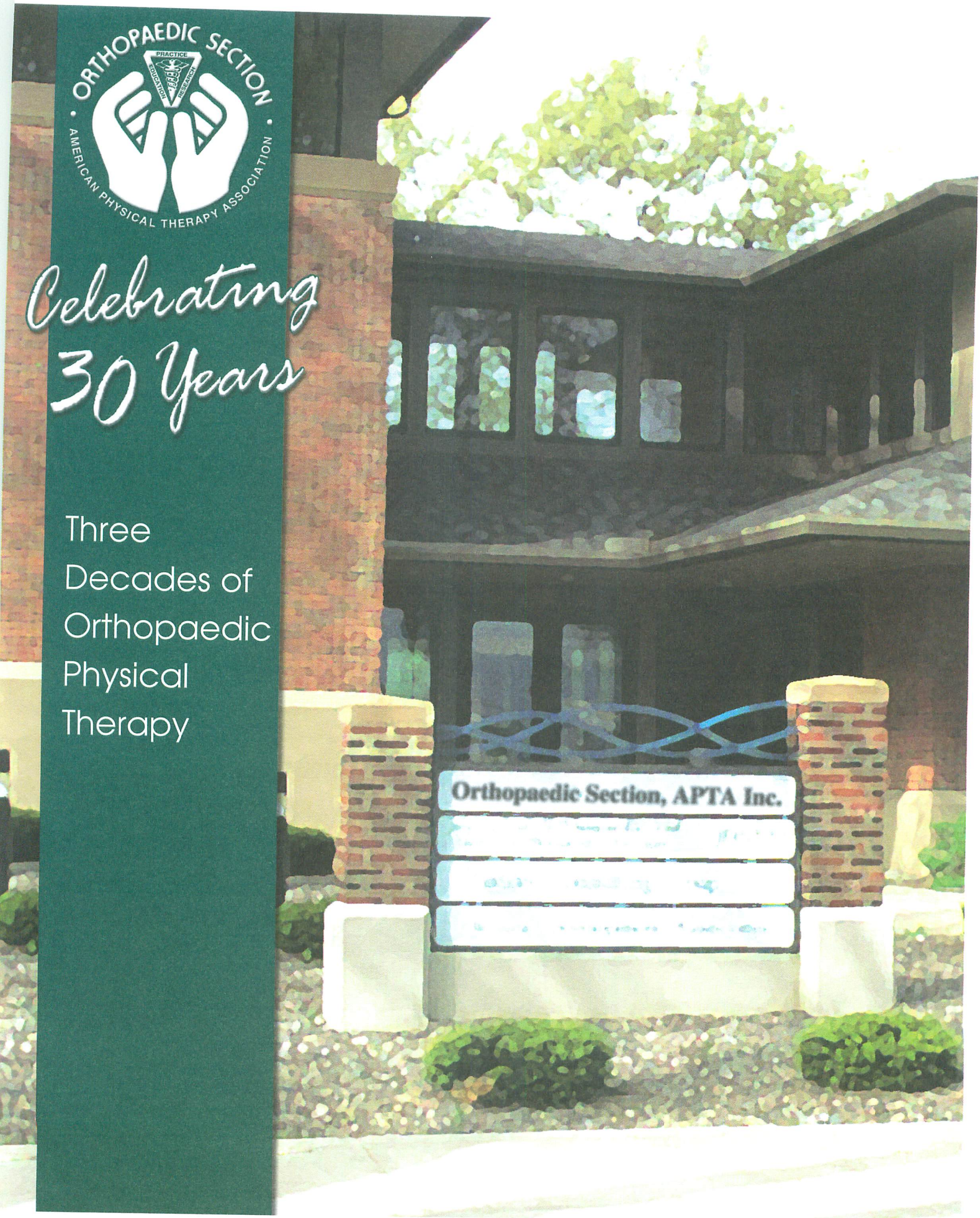
Chapter 4 addresses diagnostic buroscopy, which includes an eight-point bursa anatomy review. Basic techniques for arthroscopic shoulder reconstruction are covered in Chapter 5, including types of sutures, knots, and suture anchors. Chapter 6 describes the clinical presentation, evaluation, diagnosis, medical management and physical therapy for adhesive capsulitis. Surgical interventions described include closed manipulation under general anesthesia and arthroscopic capsular release. Chapter 7 addresses the biceps tendon, including clinical history and physical examination of biceps tendon pathology, diagnostic imaging, and treatment. Arthroscopic procedures for biceps tendon pathology are described and illustrated. Chapter 8 provides an overview of glenohumeral instability. Anatomy of instability is addressed, as is history and clinical examination. There is also information presented on X-ray and MRI of acute and chronic instability, supplemented by photographs of these diagnostic procedures. Chapter 9 presents arthroscopic reconstruction techniques for anterior-inferior instability, Chapter 10 addresses arthroscopic reconstruction for posterior instability, and Chapter 11 addresses multidirectional instability. Chapter 12 covers superior labrum, anterior to posterior (SLAP) lesions of the shoulder, including classification, diagnosis, imaging, arthroscopic evaluation, and arthroscopic repair. There is also a brief paragraph on postoperative care. Chapter 13 addresses arthroscopic treatment of the acromioclavicular joint, including clinical evaluation, conservative treatment, arthroscopic distal clavicle resection, and arthroscopic reconstruction for complete dislocation.

Chapter 14 is an introduction to clinical evaluation and imaging of the rotator cuff. This chapter will be of particular interest to physical therapists who see patients with shoulder pathology. I found the magnetic resonance images of rotator cuff tears particularly helpful in understanding this pathology. Chapter 15 describes arthroscopic classification of rotator cuff lesions. There is a brief paragraph in this chapter on decision making in the treatment of rotator cuff tears. Chapter 16 addresses arthroscopic subacromial decompression and includes a brief paragraph on postoperative care. Chapter 17 presents arthroscopic repair of partial articular supraspinatus tendon avulsions (PASTA) lesions of the rotator cuff tendon. Chapter 18 covers repair of full-thickness rotator cuff tendon and bursal flap tears. Chapter 19 addresses arthroscopic treatment of massive rotator cuff tears. Each of these chapters also include a brief paragraph on postoperative care. Chapter 20 addresses subscapularis tendon injury, including history, clinical examination, imaging, and arthroscopic treatment. Chapter 21 discusses the use of the arthroscope in evaluation and treatment of arthritis and synovitis of the shoulder. There are radiographic and magnetic resonance images of pathology associated with degenerative arthritis and photographs of arthroscopic views of arthritic shoulder pathology. Rheumatoid-type inflammatory arthritis and synovial chondromatosis and osteochondromatosis are also illustrated. There is also a paragraph on rehabilitation. Chapter 22 covers calcium deposits about the shoulder, including incidence and history, clinical presentation, diagnosis, and treatment. Arthroscopic removal of calcific deposits is described and beautifully illustrated by photographs of arthroscopic views of this procedure. Chapter 23 addresses ganglion cysts of the shoulder, including arthroscopic removal.

This monograph, written by a leader in arthroscopic surgery of the shoulder, is an excellent presentation of the current state of shoulder arthroscopy. The high-quality glossy photographs of arthroscopic procedures are a particular asset. I recommend this book for physical therapists who treat patients with shoulder pathology. Students should have access to this book as a reference in their personal or school library.

Thomas P. Nolan Jr., PT, MS, OCS


Northridge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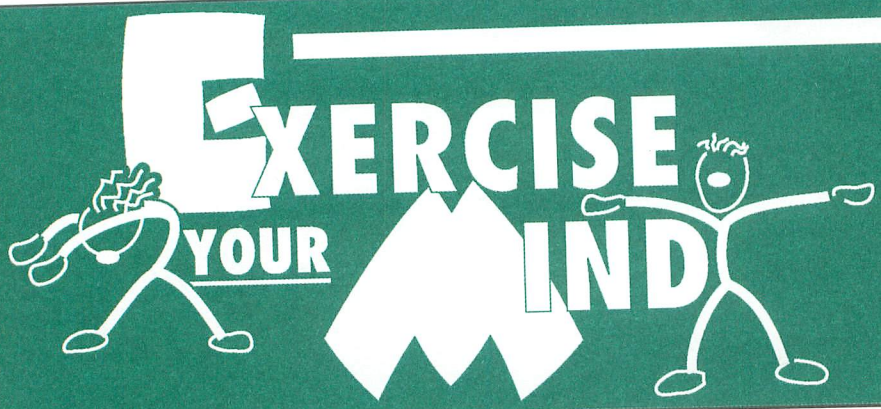

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Occupational Health Physical Therapists Special Interest Group

Orthopaedic Section, APTA, Inc.

Winter 2004

Volume 16, Number 1

As part of the 30th anniversary of the Orthopaedic Section, the OHSIG is proud to celebrate its 11th year anniversary as well. The OHSIG was formed by a broad coalition of APTA members with a dedicated interest in Occupational Health in 1992. It started with over 200 members and today numbers 657 strong.

All along OHSIG board members have represented all venues of occupational health including clinicians, researchers, entrepreneurs, academics, and industry. The OHSIG welcomes both the experienced and newly interested therapists to join the SIG and participate on the Board, Committees as well as attend our outstanding programming at CSM. The OHSIG continues to strive to promote Physical Therapists as key providers in Occupational Health prevention, treatment, management, research, and regulation issues.

Special projects the SIG has completed include the Occupational Health Guidelines. To locate, go to the APTA website, click on Publications, and you'll find the following guidelines: The Role of the PT in Occupational Health; Guidelines for Programs for Injured Workers; Evaluating Functional Capacity; Guidelines for PT Management of the Acutely Injured Worker; Prevention of Work-related Injury/Illness; Legal and Risk Management Issues and Ergonomics (in development). A large current project that will take several years is the Occupational Health PT Practice Analysis. This will help us define the scope of Occupational Health PT and then assist us in developing a specialist exam and certification process, or possibly create a residency type program format. The subject of 'certification' first came up when the SIG was first formed and the board reviewed the National Interdisciplinary Committee on Health Ergonomics (NICHE) proposed job functions and academic background of a 'Health Ergonomist.' The goal to address certification methods for PTs has been a longstanding one and was a priority for membership even back in 1993.

We look forward to expanding the knowledge and skill base for all of you with an interest in Occupational Health Physical Therapy! Stay healthy and work safe.

Karen Elton-Walz, PT, MA, OCS, CMPT
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History of the Foot & Ankle Special Interest Group

While the Foot and Ankle Special Interest Group (FASIG) was officially recognized by the Orthopaedic Section at the 1995 Combined Sections Meeting held in Reno, Nevada, the first discussions regarding the formation of the SIG were actually initiated in August 1992. In August 1992, several therapists attending a plantar pressure research meeting in Flagstaff, Arizona, met during the meeting to discuss the possibility of developing a Physical Therapy Foot and Ankle Study Group. Gary Hunt, one of the physical therapists who attended the research meeting, had already been chairing several roundtable discussion sessions for the Orthopaedic Section at past Combined Section Meetings. Since the Orthopaedic Section had already expressed interest in developing several 'special interest' groups based on the popularity of the roundtable discussions, the therapists decided to approach the Orthopaedic Section about the possibility of developing a FASIG.

It is important to note that the physical therapists who spent a tremendous amount of time and energy to get the FASIG 'off-the-ground' at this early stage were: Mark Cornwall, Catherine Patla, Michael Mueller, Irene McClay, Steve Rieschl, Debbie Nawoczenski, Margo Orlin, Michael Wooden, Max McLeod, Scott Straker, Jean DeBettignies, Gary Hunt, Joe Tomaro, Jim Birke, and Tom McPoil. While the interest for a FASIG was determined through phone calls and letters to other therapists over the next few months, the roundtable discussions continued at the annual Combined Sections Meeting in February 1993.

The first 'unofficial' meeting of the FASIG took place in June 1993 at the APTA Annual Conference in Cincinnati, OH. Approximately 30 physical therapists found a vacant room at the convention center and spent an hour and a half discussing what the purposes and functions of the SIG would be. It is very important to emphasize that at this first meeting, not only were there members of the Orthopaedic Section, but also members from the Geriatric, Sports, and Pediatric Sections. The therapists who attended this meeting wanted to see a "true" intersectional SIG with the Foot and Ankle since interest in this area was so high in several sections. Then Orthopaedic Section President Annette Iglarsh believed that an inter-sectional FASIG could be accomplished even if the FASIG was housed under the Orthopaedic Section. With that knowledge, the therapists in attendance at the meeting in Cincinnati as well as many other therapists around the country with an interest in the foot and ankle went about the process of obtaining 200 signatures from current Orthopaedic Section members so that a petition to form the FASIG could be presented the Orthopaedic Section Board of Directors at the 1994 Combined Sections Meeting in New Orleans.

At New Orleans, even though over 500 signatures were obtained in support of the FASIG, the Board of Directors asked for more time to investigate how they would manage the development and finances of several new SIGs that had petitioned to be formed and officially recognized by the Orthopaedic Section, in addition to the FASIG. While this was a bit disappointing for all of those therapists who hard worked so hard to get the necessary signatures, Orthopaedic Section Treasurer Dorothy Santi and Terri DeFlorian at the Section Office developed a standardized set of bylaws as well as a budget for all future Orthopaedic Section SIGs. Once the general SIG bylaws and budget scheme was passed by the Board of Directors, the FASIG could then be recognized officially.

The first official FASIG business meeting was held at the 1995 Combined Sections Meeting in Reno, Nevada. Also at the meeting, the first formal FASIG education session was held and provided CSM attendees with 3-hours of foot and ankle programming.

Since 1995, the FASIG has continued to play an important role for Orthopaedic and other Section members who have a special interest in the foot and ankle. In addition to providing 4-hours of specific programming on the foot and ankle each year at CSM, the FASIG has sponsored preconference instructional courses prior to the annual CSM in 1997 and in 2003. In addition, the FASIG has been able to sponsor research retreats dedicated to understanding static and dynamic evaluation of the foot and ankle. The first occurred in 2000 with the proceedings of the research retreat published in the *Journal of Orthopaedic and Sports Physical Therapy*. A second research retreat is planned for April 30, May 1, 2004 in Los Angeles.

As the FASIG begins its ninth year in existence, it continues to be an important and valuable resource for section members with a clinical and research interest in the foot and ankle.

Submitted by Thomas McPoil, PT, PhD & Stephen Reischl, DPT, OCS

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Performing Arts Special Interest Group • Orthopaedic Section, APTA

Congratulations on 30 Years, Orthopaedic Section!

The Performing Arts Special Interest Group (PASIG) began in 1994 and our first President was Sean Gallagher, who served a 2-year term and continues to practice in New York City. The PASIG began with 216 supporters and doubled to our current membership at 432. Our members represent a varied interest level within the arts community with treatment of dancers and their injuries as most represented. The management of musicians, figure skaters, gymnasts/circus performers, and actors also are included. We asked some of our past Presidents (we're currently on our fourth) how they are doing and for a few of their memories about the PASIG. Here are their responses:

(BA) Brent Anderson, PT, OCS (PASIG's second President); served 1996-1998; currently practicing in Miami, Florida; continues to lecture and consult on dance and music medicine; currently in his last year of finishing the dissertation for his PhD at the University of Miami; serves as adjunct faculty at University of Miami.

(JG) Jennifer Gamboa, MPT, OCS (PASIG's third president); served 1999- 2001; currently in private practice in Arlington, Virginia; teaches at the Kirov Academy of Classical Dance.

(JS) Jeff Stenback, PT, OCS (PASIG's fourth and current president); serving 2002-2004; currently in private practice in Miami, Florida; compiling research data on health care pattern usage in musicians; continues to perform locally as a vocalist in the South Florida region.

1. What were the major issues confronting you during your term as President?

(BA) Major issues that we confronted consisted of refining the organization of the PASIG in its second term. We focused on further defining our niche within the Orthopaedic Section and our developing relationship with other component Sections such as the Sports and Hand Sections. One of our other primary focus areas was in the recruitment of PTs who had not previously belonged to the APTA.

(JG) Major issues during my presidency were to grow the PASIG's membership, improve the level of programming, increase participation of and ownership by the membership, help PASIG mature in its role within the Orthopaedic Section, and develop a description of specialized practice.

(JS) We have had the completion of our Description of Specialized Practice (DSP), which has led to a need for specific strategic planning for how our special interest group will continue this momentum and grow into the future. We are reaching out to more of the performing arts community and sharing our expertise. This has necessitated a greater focus on injury management from the preventative/risk management side with a greater need to provide evidence for what we do.

2. What do you see as your legacy to the PASIG as a result of your presidency?

(BA) We established an informal research coaching format for therapists within the PASIG and we worked to forge strong links between external multi-disciplinary organizations, like PAMA and IADMS.

(JG) Description of Specialized Practice, and leaving the Executive Board in the hands of individuals who were also dedicated to growing PASIG's professional role within the Orthopaedic Section, and raising the professional bar for its members.

(JS) I believe that my legacy will have been the establishment of the basics of a working strategic plan within our organization that helps guide three specific areas. Educational objectives using our completed Description of Specialized Practice (DSP) for the Performing Arts to guide educational programming which could lead to, ultimately, a residency program; Practice objectives which ensure that issues are addressed that affect how performing arts physical therapy is delivered; Research objectives that help identify pertinent clinical questions and foster the research that enables practicing clinicians to rely on evidence-based work for their treatment programs.

3. What is your most enduring memory of your time as PASIG's President?

(JG) Dedication of the Executive Board members; the total, unconditional support of the Orthopaedic Section office to help this roundtable organize and grow into meaningful/purposeful special interest group. I felt like Bill Boissonnault, Nancy White, and Tara Fredrickson took my hand and

showed me how I was suppose to interact in a larger professional context, and by giving me such positive support, helped me shepard the PASIG to a new level of credibility.

(JS) I know that I will remember a great deal of my time as your president. But I have enjoyed the chance to get to know more about our Orthopaedic Section, how it functions and how the special interest groups fit into the Section's strategic goals. I have enjoyed our diversity within the performing arts specialty and our willingness to reach out into the performing arts community as teachers, healers and advocates.

4. What role do you see the PASIG playing in the coming years within the profession of physical therapy?

(BA) I see the PASIG becoming a source of expertise for the performing arts on the medical and legal fronts within industry for health issues in performing artists. The finalization of our practice analysis; our participation in state reciprocity issues for traveling therapists; and our focus on developing programs that encourage and develop competent performing arts physical therapists all are leading us to this place as health care leaders within the performing arts community.

(JG) I see the PASIG supporting the profession's drive towards evidence-based practice, clinical residencies, and/or fellowships. The PASIG is in a unique position to help lead its members towards a more rigorous level of practice — whether it's through designing continuing education courses to address competencies within the DSP; acting as a clearinghouse for the compilation of evidence for each area of competency within the DSP; and endorsing or helping to develop performing arts residency programs.

(JS) I envision the PASIG as continuing to be a strong partner in developing a stronger special interest area through defining better how we practice, continuing to develop relationships with other arts organizations and acting as advocates within the performing arts community at large. Our ability to plan where we want to be in 5 years will continue to be important. The work that we do now will create more opportunities and better performing arts therapists for the future.

The PASIG represents a wide diversity of performing arts—dancers, musicians, figure skaters, circus performers, and actors. We continue to grow and develop deeper relationships with the performing arts community at large. Our outreach must focus on not only finding better and more efficient treatment for injuries in the performing arts community, but must also focus on prevention, risk assessment and education. We must continue to develop our mentoring capabilities and act as a resource for the most current information in our specialty area. The PASIG wishes to thank the Orthopaedic Section for its support over the last decade and we hope to maintain a strong presence within and as a representative of the Section. Congratulations to the Orthopaedic Section on its 30th year anniversary!

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Pain MANAGEMENT
SPECIAL INTEREST GROUP • ORTHOPAEDIC SECTION, APTA, INC.

How Laser Therapy Works

James L. Oschman, PhD, Jeff Spencer,DC., Joe Kleinkort, PT, MA, PhD, CIE

"The real voyage of discovery consists not in seeking new lands but in seeing with new eyes." Marcel Proust

Because of the increasing popularity and success of laser therapy, we would like to know more about how coherent light affects living systems. While our picture is not yet complete, we know enough to provide helpful information for both the patient and the therapist. Experience shows that a clearer understanding of what coherent light or any other energetic treatment is doing can actually enhance the therapeutic encounter in several ways.

THE CIRCUITRY OF THE BODY

Recent research in cell biology has described a continuous microscopic matrix that extends into every part of the organism, including into every cell and into every nucleus, of all cells, throughout the body. This system is called *the living matrix*. The key elements in this system are the collagen-rich connective tissues (tendons, ligaments, fascia, cartilage, bone), the cytoskeletons of the various cells, the nuclear matrices that support the genetic material, and the integrins. The latter are trans-membrane proteins that link the cell interior with the extracellular or connective tissue matrix.

We have known for some time that this entire matrix has semiconductor properties, although this fact is not widely appreciated. The 2000 Nobel Prize in Chemistry is for the discovery of semiconducting polymer films, and comparable materials exist through the human body as planes of fascia. Semiconductors are the materials that provide the basis for our modern electronics industry, including computers. Many of the remarkable successes of laser and other therapies can be explained by reference to this remarkable whole-body system with its electronic and solid-state properties. The term, *solid state*, refers to a branch of physics dealing with condensed or solid matter. Research in this area helps us understand a number of phenomena that have considerable significance for the study of life and the healing response. Let us summarize some of these.

NONLINEARITY

First, the living matrix is a nonlinear system. This means that very tiny influences, such as the application of small amounts of light or sound or other energies, can produce large effects.[1] This is particularly the case if the energy is introduced at especially sensitive areas on the body surface. Various therapeutic systems utilize such highly responsive regions which are variously termed trigger points, acupuncture points, critical points, and chakras.

Extensive research has documented that the 'less is more' principle, the hallmark of homeopathy, applies to any therapeutic intervention. We are learning that if the therapy does not seem to be effective, we should always try using *less* energy, rather than more. Cells actually respond better to very tiny 'whispers' than to larger stimuli. This phenomenon is described in the biophysical literature as 'windowing.' A window is a narrow region in the frequency spectrum and in the range of intensity that will provide a biological response.[2] Each type of cell, and each tissue, appears to respond best to a particular frequency or set of frequencies.[3] These frequencies must be provided at a sufficiently small intensity or there will be no effect. One reason for the frequency specificity arises from another attribute of the living matrix, *crystallinity*.

CRYSTALLINITY

Large portions of the living matrix are composed of crystalline or nearly crystalline matter. The fact that the molecules in these parts of the matrix are closely packed together, in highly organized and evenly spaced or *coherent* arrays helps us understand the effectiveness of coherent light. In fact, the crystalline arrays found in living matter are described as liquid crystals. These are materials that have properties of both solids and fluids. Their properties are nicely summarized by Ho:[4]

Liquid crystallinity gives organisms their characteristic flexibility, exquisite sensitivity and responsiveness, and optimizes the rapid noiseless intercommunication that enables the organism to function as a coherent coordinated whole.

A number of scientists, looking at these highly organized liquid crystalline systems, predicted that energy input into such materials should cause the molecules to begin to vibrate in unison. In other words, when a certain energetic threshold is reached molecular arrays should vibrate coherently at particular frequencies in the visible and near-visible part of the

electromagnetic spectrum. Research has shown that this is indeed the case. The scientific literature on this subject is of great interest to all therapists, and several articles are highly recommended.[5,6] Unfortunately the first of these publications is out-of-print, and second is in German. However, the interested reader can find fully referenced summaries in several publications.[7-9]

LIGHT AS INFORMATION

The research just cited has led a number of scientists to realize that for the body to function in a coordinated or coherent manner, there must be some kind of signaling system that enables every part to "know" what every other part is doing. The phenomenon is best exemplified by peak athletic or artistic performances in which one has the impression that every tissue, cell, and molecule of the body is being utilized in a perfectly harmonious manner. This has been referred to as *systemic cooperation.*[7] This state is also encountered from time to time during peak therapeutic encounters, when the therapist and patient both can have a remarkable sense of interconnectedness. Hence the exploration of systemic cooperation has significance for all endeavors.

A distinguished German researcher, Fritz Albert Popp, has suggested that coherent light is the most likely candidate for the information carrier in living systems. If he is correct, the coordination of living processes is an ultra-fast process. Researchers at the University of California in Irvine have documented such ultra-fast phenomena exist in the human body.[10] Specifically, when they used non-contact ultrasonic stimulation of "vision points" on the foot, functional magnetic resonance revealed that neurons in the visual cortex were responding far too quickly to be explained by nerve conduction. Some non-neural carrier of information was conveying the "message" from the feet to the brain.[11] Light is a very good candidate for this ultra-fast communication. Certainly the system being studied by Jones provides an opportunity to study ultra-fast communication processes in living systems.

The 'noiseless' attribute of intercommunication, mentioned in the quote from Mae-Wan Ho above, is of great interest. Because intercommunication is noiseless, and because it is not mediated by the nervous system, we are not usually consciously aware that such communication is taking place. It has been suggested that this subconscious noiseless non-neural communication system is actually the body's *operating system*, working silently in the background, coordinating all living processes, including injury repair and protection from disease.

CLINICAL SUMMARY

Our clinical use of low power cold laser technology has shown its profound capacity to reduce inflammation, improve range of motion, engage proprioception and integrate locomotor processes. An astonishing aspect of this is the speed and longevity of the changes. Re-establishing strength in muscles that test 3+ on neurologic examination most often occurs within seconds of laser stimulation and remains strong until further trauma. The same results are seen with increases in joint range of motion. This is seen with high predictably in old joint injuries, particularly in the shoulder. Swelling in acute traumatic soft tissue injury decreases significantly within minutes of laser therapy. The sooner the laser is applied, the more profound the response. When used early in rehabilitation low level laser dramatically facilitates the integration of injured joints and muscles into complex locomotor movement patterns. This is critical, as it appears, that early movement creates the reorganization of the body's tissues necessary to integrate strain-free, energy efficient full body movement.

The speed and profound effects of the laser are clinically amazing. Specifically in the area of acute and chronic pain the reduction is fast and dramatic. Moreover the effect of the laser is long lived unless the patient over taxes the area of involvement. The need to neuromuscularly challenge the affected area cannot be underestimated. Significant increases in ATP also seem to be the reason that the muscle is reset so rapidly.[12]

The use of various frequencies of laser also increase the rapidity and longevity of the results. We are on the edge of a revolution in the clinical treatment of the patient and with further training and knowledge we will step into the future of fast, safe and effective methodologies such as the laser. It is time that therapists avail themselves of this remarkable technology to assist the patient to overcome pain and musculoskeletal dysfunction. The time to act and enjoy the new paradigm is now.

SOME CONCLUSIONS

The material summarized here begins to develop a picture of a whole-body living matrix with remarkable properties. It is of interest to both the patient and the therapist using lasers that coherent light can affect the entire living matrix. This means that the effects reach into every nook and cranny of the body. Because many of the cellular enzymes are located on the cytoskeletal matrix, coherent energies moving through the fabric of the body can reach and affect biochemical pathways. Because this is the body's operating system, coherent energies moving through the matrix can open up or *exercise* regulatory pathways. This opening up of pathways is of great importance in facilitating healing; it is also of value to the athlete or other performer seeking full body systemic cooperation in order to maximize the operations of their sensory and movement systems.

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SPECIAL INTEREST GROUP

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

1. Proceedings of the 2nd International Symposium for Rehabilitation and Physical Therapy in Veterinary Medicine – August 2002, Knoxville, TN. Available now for $20. They are a great resource. Contact David Levine at david-levine@utc.edu.
2. Orthopaedic Section Member and Nonmember directories are available through the Section Office 800-444-3982 Fax: 608-788-3965 or E-mail: tfred@orthopt.org . There currently are 544 members.
3. State Liaisons: To date there are 33 states that have Animal SIG Liaisons.
4. The APTA has a web site that lists all of the State Practice Acts: www.apta.org/advocacy/state/state-practice.
5. The office of Nominating Committee Member is still awaiting nominations. Please contact Amie Lamoureaux–Hesbach using her contact information with any nominations.

REHABILITATION AFTER SURGICAL STABILIZATION OF CRANIAL CRUCIATE LIGAMENT-DEFICIENT STIFLE JOINTS

Denis J. Marcellin-Little, DEDV, CCRP, Diplomate ACVS, Diplomate ECVS, College of Veterinary Medicine, North Carolina State University, Raleigh, NC

Many research projects have documented the benefits of physical therapy for people undergoing surgery after anterior cruciate ligament injuries. Similarly, several clinical studies have documented the benefits of postoperative physical rehabilitation programs on the recovery of dogs after surgical exploration and stabilization of CCL-deficient stifle joints. From a clinical standpoint, the design of a rehabilitation program after CCL surgery is challenging because many factors influence limb use and return to function after surgery. Well-designed rehabilitation plans consider all these factors.

FACTORS INFLUENCING THE REHABILITATION PLAN

Patient Profile – The patient profile is a key factor in designing a rehabilitation plan. A young dog may be less socialized, less patient, and more enthusiastic than an adult dog. The duration of each intervention is generally decreased in young dogs, and interventions that represent outlets for their exuberant energy may be preferred. Also, the healing response and physiological changes secondary to their pathology and surgery is exaggerated in young dogs compared to older dogs. The rehabilitation program in puppies is therefore generally more aggressive and should be implemented without delay, immediately after surgery. Older dogs may have less muscle mass and overall fitness than middle-aged dogs and therefore decreased mobility. The rehabilitation program of older patients may need to focus on that potential lack of fitness and muscle weakness. Patient size is an important factor during rehabilitation: dogs of large breeds may prefer interventions that involve more active motion (exercise-based) but dogs of small breeds may prefer interventions that involve less active motion (passive range of motion, superficial heat, stretching). The body condition

of the patient greatly influences their rehabilitation program. Overweight dogs, for example, may have decreased mobility and will function better during aquatic exercises than land-based exercises. Exercises that may lead to an increase in body temperature should be avoided in overweight dogs.

Joint pathology –The rehabilitation plan is influenced by the conformation and specific pathology of the patient. The chronicity of the CCL injury also influences the degree of disease and the rehabilitation plan after surgical treatment. When CCL injuries are chronic, synovitis and thigh muscle atrophy may be more severe. The overall limb alignment is taken into account. For example, if a patient has genu valgum (cow-hocked appearance) or varum (bow-legged appearance) specific exercises that may increase the stress placed on the medial or lateral collateral ligaments should be avoided. The amount of osteoarthritis (OA) present in the stifle joint influences the rehabilitation plan. A dog with moderate or severe OA may benefit from a slower, more progressive rehabilitation plan compared to a dog without OA. The amount of preoperative periarticular fibrosis will likely influence limb function in the postoperative period because of potential limitation in joint extension. A dog with such fibrosis will likely need repeated superficial (hot pack) or deep heating (therapeutic ultrasound) of the stifle joint prior to stretching of the caudal aspect of the joint capsule.

Surgical method – The most common surgical method used for the management of CCL injuries is an open stifle joint arthrotomy and extracapsular stabilization. These methods lead to moderate tissue trauma with relatively long skin, fascial, and articular incisions. Tissue trauma is decreased when the arthrotomy is distal to the lateral or medial parapatellar fibrocartilage and the patella is not luxated during surgery, or when arthroscopy is used. In some instances, CCL injuries are treated with a tibial plateau leveling osteotomy (TPLO). The TPLO is more invasive than extracapsular stabilization because in addition to the arthrotomy (and a potential partial medial meniscectomy), a medial approach to the proximal part of the tibial shaft and a corrective osteotomy are performed.

REHABILITATION GOALS

Weight bearing – Painful sensations originate from the CCL-deficient stifle joint. These sensations result from synovitis, from the pivot shift (cranial thrust) present during weight-bearing activities, or from the presence of a meniscal tear or fold. The primary rehabilitation goal will be to restore weight bearing of the affected limb. Increasing weight-bearing activity is generally achieved in the short term through a decrease in joint inflammation (rest, ice, passive range of motion) and in the longer term through a restoration of the muscle mass of the affected limb (therapeutic exercises). In order to decrease the amount of weight placed on CCL-deficient joints, dogs will shift weight away from affected joints. With unilateral CCL injuries, dogs shift weight towards their opposite pelvic limbs. With bilateral injuries, dogs will shift weight forward (Figure 1). The severity of the weight shift appears to increase with time.

Posture (stifle joint extension, gait) – The extension or flexion present in CCL-deficient joints may be decreased. These changes in joint motion may have profound consequences on the posture and limb function. Extension is particularly important to stifle joint function because a loss of extension will limit dogs' ability to stand, walk, trot, and gallop normally. The same rules apply to people with anterior cruciate ligament tears. Normal dogs have 160 to 164° of maximal extension in their stifle joint. When standing, they may hold their stifle joints at 130 to 140°, and when walking and trotting they may place their stifle joint at up to 155 to 160°. Dogs with CCL-deficient stifle joints may lack extension. The cause of that lack of extension is not known, but may result from the presence of an abnormally steep tibial plateau slope, from thickening or fibrosis of the joint capsule, or from other causes.

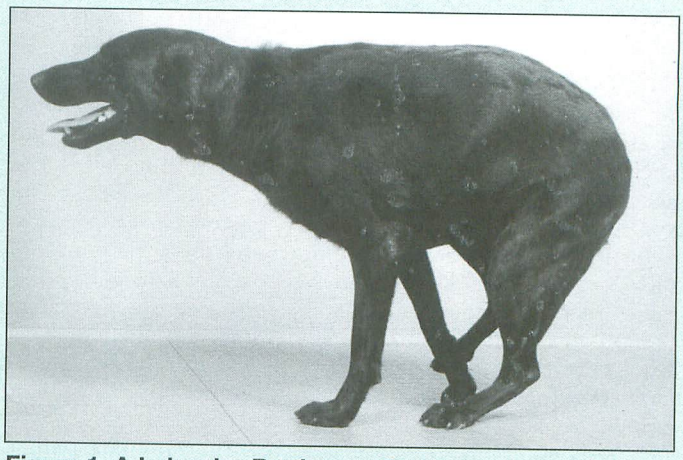

Figure 1. A Labrador Retriever with bilateral cranial cruciate injuries shifting weight forward.

The lack of extension will interfere with stance and stride. Regaining extension may sometimes require a corrective procedure (TPLO or other procedure). Extension may also be increased through superficial (heat pack) or deep (therapeutic ultrasound) heating and stretching in the short term and through therapeutic exercises (Cavaletti rail, underwater treadmill, walking uphill) in the mid-term. Stifle joint flexion also may be limited in CCL-deficient stifle joints, especially after a TPLO procedure. While limited flexion has little impact on walking and trotting, it negatively impacts sitting, squatting, and other activities. Like extension, flexion may be regained though heat, stretching, and therapeutic exercises.

Beyond the gait anomalies that result directly from abnormal joint flexion and extension, several gait anomalies are often present in dogs in the weeks that follow surgical treatment of CCL injuries. These anomalies include external rotation of the limb (particularly after extracapsular stabilization), limb abduction, and reluctance to sit straight. These anomalies are treated using therapeutic exercises including sit-to-stand exercises, step and stair climbing, and underwater treadmill exercises.

Muscle mass – Approximately one third of the mass of all pelvic limb muscles is lost within a few months after injury or within a few weeks after surgery. The recovery of that muscle mass requires weight-bearing activities (land-based and aquatic therapeutic exercises).

REHABILITATION INTERVENTIONS

The rehabilitation interventions used in the recovery after CCL include cold therapy, passive range of motion, massage, weight-shifting exercises, superficial and deep heat therapy, stretching, and therapeutic exercises.

Cold therapy is used in the immediate postoperative period to decrease local inflammation and pain. A cold pack is placed on the medial, cranial, and lateral aspects of the stifle

joint or is wrapped around the operated limb. In people, cold packs have been shown to decrease the temperature of arthritic knee joints for more than 3 hours. Heat therapy may be used to relieve muscle spasm and to enhance the benefits of stretching. Heat may be superficially delivered using hot packs. Deep heating, below a depth of 3 cm (1 1/4") is achieved using therapeutic ultrasound.

Massage may be used in the early postoperative period to help eliminate the edema present around the stifle joint and the crus. Gentle strokes are generally used in a distal to proximal direction. Ice massage may be considered. Passive range of motion, stretching, and Grade I-II joint mobilization may be used in the early postoperative period to relieve pain, to improve joint lubrication, and to address limitations in joint motion.

Therapeutic exercises are used to help eliminate pathologic weight shifts and other compensatory postural positions (abduction, external rotation), to stretch joints, and to rebuild muscle mass. Therapeutic exercises may include leash walk, Cavaletti rails, uphill walking, stair climbing, sit-to-stand exercises, and aquatic therapy in an underwater treadmill or swim tank. Weight-shifting exercises may be used to decrease pathological weight shifts and to enhance proprioception of the affected limb. These exercises include standing on soft surfaces, balance boards, or exercise balls.

SUMMARY

The postoperative rehabilitation after stabilization of CCL-deficient stifle joints is complex and is aimed at decreasing local inflammation, restoring normal joint motion, eliminating weight shifts and other compensatory postures, and rebuilding muscle mass. This is achieved in the early postoperative period by using cold therapy, passive range of motion, stretching, and weight shifting exercises. Later, therapeutic exercises are used to continue restoring proper posture and stride length and to rebuild muscle mass.

References available upon request: denis_marcellin@ncsu.edu

FROM: DEBBIE GROSS SAUNDERS

The Orthopaedic Section recently held its strategic planning meeting which I unfortunately could not attend. However, Amie Lamoreaux Hesbach attended in my absence. Many positive factors were discussed in regard to the Animal PT SIG.

After speaking with Amie, I would like to set the following goals for the SIG for the next year and I encourage members to become involved.

1) A preconference course at CSM 2005
2) Develop a packet of information on animal rehab for insurers for both animal insurance and for malpractice and liability insurance.
3) Communication with the officers through two conference calls—one prior to the CSM and one 6 months after.
4) Advancement of the present SIG website.
5) Update the present SIG liaison list. Currently the SIG liaison coordinator position is open and we will need to fill it as soon as possible.
6) Increase the responsibilities of the individual state SIG liaisons.

STRATEGIC PLANNING REPORT

Amie Lamoreaux Hesbach, MSPT, CCRP
Nominating Committee Chairperson, Animal Physical Therapist Special Interest Group

I recently represented the Animal Physical Therapist Special Interest Group (APTSIG) at the Orthopaedic Section Strategic Planning Retreat and Fall Meeting in LaCrosse, Wisconsin. Following is my personal perspective concerning the retreat as it applies to the activities of the APTSIG. To be honest, I wasn't terribly excited about attending the meeting, believing that I wouldn't be very involved in the planning process and that the APTSIG wouldn't be high on the list of priorities for the Section. Boy, was I pleasantly surprised by my experience!

As I've been an APTA member since my days in physical therapy school and an Orthopaedic Section member since prior to my involvement in animal rehabilitation, I've had certain expectations of the 'benefits of belonging.' Not only do the APTA and Orthopaedic Section provide exceptional journals, but both are politically-active organizations serving as advocates for me and other physical therapists and assistants. I have confidence that the APTA and Orthopaedic Section will continue to lobby for legislative and regulatory changes that will benefit physical therapists, physical therapist assistants, and our patients and clients. In the same way, I assumed that the APT SIG would do the same. The SIG, though, is very young and is slowly growing and evolving as a potentially influential organization.

The field of animal rehabilitation is a dynamic one in which we, as physical therapists and assistants, have a potential influence clinically, through evidenced-based practice, in education, and in legislation. A topic that was discussed at the Strategic Planning Retreat was that of encroachment on the practice of physical therapy by chiropractors, massage therapists, personal trainers, and the like. Animal rehabilitation is yet another field in which we might pre-emptively protect our exceptional knowledge and skills and, rather, establish a collaborative relationship with the veterinary community. I have heard that a drive by Ben Massey to establish a liaison with the AVMA in the recent past was not successful; however, recent meetings of the Federation of State Boards of Physical Therapy have yielded positive discussions amongst chiropractors, veterinarians, and physical therapists.

The APTSIG was encouraged and challenged by the Orthopaedic Section leadership to do some strategic planning of its own. As the mission, vision, and goals of the Orthopaedic Section have evolved, so should those of the APTSIG. It seems that though the goals of the SIG resemble those of the Section (and of the Association), we, however, have a more specific focus.

A draft of the Orthopedic Section mission, vision, and goals, including objectives and strategies, will be presented to the membership for discussion prior to the Combined Sections Meeting 2004. I invite you to review these working documents and to freely share your thoughts and opinions. Debbie Gross Saunders, our APT SIG President, has included a draft of the specific SIG goals in this newsletter and welcomes your comments as well. The Section goals focus on these specific realms: practice (including legislation, regulation, reimbursement, advocacy, direct access, and primary care), professional development and education (referring to home study courses, Combined Section Meeting programming and preconference courses, residencies, and fellowships), technology and communication (including website development), member recruitment, retention, and development, organizational and fiscal solvency, and research (as demonstrated by evidence, outcomes, and efficacy).

The facilitator of the Strategic Planning Retreat encouraged brainstorming for the development of Section-specific goals for 2004-2007, but she unknowingly influenced further

brainstorming by me and other Section members concerning the vision and goals of the APT SIG. Some of these ideas were: the development of further continuing education opportunities for SIG members, including pre-conference courses at the Combined Section Meeting, development of new home study courses (including feline anatomy, physiology, and gait, veterinary pharmacology, and pet-assisted therapy), the potential for dual credentialing of physical therapists and assistants in veterinary technology or veterinary medicine, and the role of the SIG in influencing legislation, regulation, and reimbursement (especially in a growing pet insurance market).

Given the potential influence that the APTSIG can have in the field of animal rehabilitaiton in the near future, it seems that this is an opportune time to reorganize and re-energize the APTSIG. Many of us have become involved due to our personal and professional interest in animal rehabilitation and our vested goal to encourage collaboration of physical therapists and veterinarians in animal rehabilitation. I encourage you to influence the direction of the APTSIG by volunteering for an office or as a committee member, by serving as a state liaison, by contributing an article to the APTSIG newsletter in *Orthopaedic Physical Therapy Practice*, by performing clinical research in animal rehabilitation, or by sharing your thoughts and opinions with any of the SIG officers.

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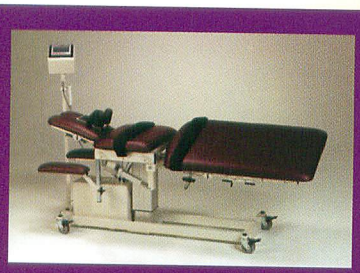

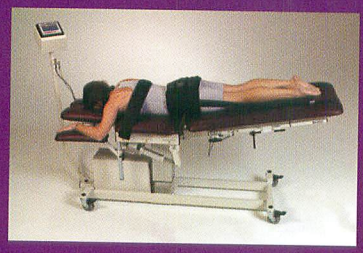

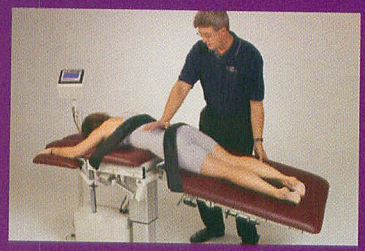

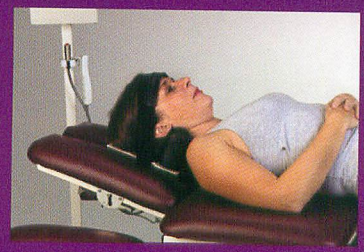

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