MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

2349

2003 SENATE HUMAN SERVICES

SB 2349

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2349

Senate Human Services Committee

☐ Conference Committee

Hearing Date February 4, 2003

Tape Number	Side A	Side B	Meter #
1		X	Tape misfunctioned
2	X		0 - 101
3	X		0 - 160
Committee Clerk Signature	Donna Kramer		

Minutes:

SENATOR JUDY LEE opened the public hearing for SB 2349.

SENATOR RICHARD BROWN introduced SB 2349 relating to the chiropractic practice.

CAL ROLFSON, lawyer and legislative counsel for North Dakota Chiropractic Association, testified in support of SB 2349. He stated this bill does not intend to restrict anyone from practicing spinal manipulation or spinal adjustment who may have the appropriate training. The bill states that unless you have adequate classroom hours, diagnosing skills and adequate clinical training at facilities that specialize in such procedures, you cannot do spinal manipulation or spinal adjustments. Amendments recommended. (Written testimony, graphs and charts, definitions and proposed amendments attached)

DR. PAUL ELLENBECKER, practicing chiropractor of 16 years and served on the Board of Directors of the North Dakota Chiropractic Association, testified urging support of the bill.

Oldest form of practice - spinal manipulation. Definite need for establishing standards of training and education of individuals who perform spinal manipulation. (Written testimony)

DR. JERRY BLANCHARD, Chiropractic physician from Grafton practicing in North Dakota for 35 years, testified in favor of the bill. He stated that diagnosis is on-going. No cost on bill. (Written testimony) (Tape 2 malfunctioned - no recording, Tape 3, Side B 0 - 135)

SENATOR LEE closed public hearing for SB 2349. (Meter 160)

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2349

Senate Human Services Committee

☐ Conference Committee

Hearing Date February 10, 2003

Tape Number	Side A	Side B	Meter #
1	X		756 - 2522

Committee Clerk Signature Donna Kramer

Minutes:

SENATOR JUDY LEE opened SB 2349 regarding the chiropractic practice for committee discussion. The discussion had been whether or not to limit the regulations concerning manipulations or to broaden the restrictions to manipulation to any profession that would involve any kind of spinal work. ... Some concerns moving out of the scope of practice. (Meter 929 - 1196)

SENATOR ERBELE questioned whether there were different skill levels?

SENATOR LEE stated absolutely. Read letter from sister who works at the Craig Institute in Denver regarding physical therapy. (Meter # 1250 - 1400)

CAL ROLFSON, lawyer and legislative counsel for the North Dakota Chiropractic Association, responded. Stated research of the state of the law (provided copy on massage therapy and physical therapy) indicates that is not with the scope of it. ... It is just those that don't have the

skill with zero training that have the capability of injuring people and providing further costs and care problem that we want to address. (Meter #1426 - 1562)

SENATOR LEE: Not clear why bill is important? (Meter # 1584 - 1625)

CAL ROLFSON: Claims made in other states. Continued discussion regarding leaving bill as it is without an amendment. (Meter # 1629 - 1885)

SENATOR LEE asked for committee discussion on either of the amendments.

SENATOR FISCHER made a motion to move amendments that Mr. Rolfson submitted.

SENATOR LEE stated that it would mean it would affect other professions other than physical therapy.

SENATOR BROWN seconded the motion.

SENATOR LEE asked for discussion on amendment. Continued discussion on erroneous testimony as to number of class hours, changes in the future, and differential diagnosis. (Meter # 2013 - 2458)

SENATOR LEE asked permission of people who made the motion to move on and locate a person who represents the physical therapists. (Meter # 2522)

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2349

Senate Human Services Committee

☐ Conference Committee

Hearing Date February 10, 2003

Tape Number	Side A	Side B	Meter #
2	X		2233 - 2277
Committee Clerk Signature	Donna Kramer		

Minutes:

SENATOR JUDY LEE opened the discussion on SB 2349.

SENATOR FISCHER withdrew his motion to accept amendment. (Meter #2256)

SENATOR BROWN withdrew his second on the motion to accept amendment.

Discussion closed at this time.

2003 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2349

Senate Human Services Committee

☐ Conference Committee

Hearing Date February 11, 2003

Tape Number	Side A	Side B	Meter #
2	X		135 - 3938

Committee Clerk Signature Donna Kramer

Minutes:

SENATOR JUDY LEE reopened the committee discussion for SB 2349. She said she talked to chiropractor about this bill. His concern that it takes a long time to learn how to do manipulation processes. ... I have a problem with an umbrella bill that affects the regulatory boards of various professions. ... Physical therapists are regulated by a board as are chiropractors. So far, in North Dakota, we haven't had any complaints about the quality of care provided by any of these professions that could reflect on the board that regulates them.

There were University of Mary students who are studying physical therapy in the committee room.

CRAIG SCHNEIDER, a two-year student studying Physical Therapy at the University of Mary, spoke. He is an athletic trainer and does on-site emergency care for athletics or any physical people. There are no manipulations.

SENATOR LEE: One of the chiropractors who had testified mentioned the fact they hear occasionally about an athletic trainer who cracking the back. Overstepping their bounds?

CRAIG SCHNEIDER: Not such much as an entry level athletic trainer.

JACK MCDONALD, lobbyist for the Broadcasters Association, spoke. He passed out copies of the Study of Spinal Manipulation from the Virginia Board of Medicine. One of the concerns raised was the training and the background of physical therapists. Referred to information in the study and the charts. He stated there have been no complaints in North Dakota of Physical Therapists performing spinal manipulation. Referred to letters in the study. The last five sheets indicate the material indicating the program in physical therapy at the University of Mary. (Meter # 463 - 1043)

DR. JOELLEN ROLLER, Professor at the University of Mary and Program Director, spoke. Shocked to read testimony from chiropractors because it doen't sound like anything of the physical therapy school, even back to my own training way back in the early '70s. I assure that our therapists are well trained. ... They learn diagnosis from day one. ... Advnacing teaching. Some students taking manual therapy ... have practice restricted is unfair. ... Bill states diagnosis as well as treatment. BCBS has agreed to pay for services without going through a physicain. ... Diagnosis are only physical impairments. Chiropractors use spinal manipulation. (Meter #1050 - 1470)

SENATOR FAIRFIELD: What specifically in the bill would prohibit them from doing that, if they have the additional training you talked about?

DR. JOELLEN ROLLER: I think the bill is so many hours of training. Chiropractors use spinal manipulation exclusively and we have a whole repetroire of treatment - spinal manipulation only being a small part of it. (Meter # 1495 - 1552)

Continued discussion with committee regarding referral by a physcian to get BCBS, have Board of Physical Therapists, physcial therapy should not be limited, and discussion about manipulations. (Meter # 1553 - 1942)

STEVEN ZIEGLER, Physical Therapist and Professor at the University of Mary, spoke. He said he teaches along the orthopedic content. Give students a sampling of different techniques. We require four different clinical experiences. To be licensed in North Dakota, you need to graduate from an accredited program in physical therapy and pass the National Licensing Exam. Beyond that, we are required to have 25 hours of continuing education credits every two years. (Meter #1972 - 2346)

JACK MCDONALD: The Board is very rigorous about the continuing education requirements. They do require all physical therapists and do examine all the continuing education components. No trademark or nobody owns the field of spinal manipulation. (Meter #2346 - 2523)

Committee Discussion:

CAL ROLFSON: No substitute comments. ... If committee lowers hours, the Board has no problem. Further discussion with committee regarding curriculum. (Meter # 2578 - 3004)

SENATOR ERBELE: Solution looking for a problem. Suggested putting McDonald's amendments on the bill. Further committee discussion. (Meter # 3027 - 3517)

SENATOR POLOVITZ made a motion DO NOT PASS.

SENATOR ERBELE seconded the motion.

Roll call was read. 3 yeas 3 nays. Motion failed.

SENATOR FISCHER made a motion to add McDonald's amendments to the bill.

SENATOR POLOVITZ seconded the motion.

Roll call was read. 5 yeas 1 nay. Motion passed.

SENATOR FISCHER made a motion to DO PASS as amended with McDonald's amendments.

SENATOR POLOVITZ seconded the motion.

Roll call was read. 6 yeas 0 nays. Motion passed.

SENATOR FAIRFIELD will be the carrier. (Meter # 3938)

38368.0101
Title.0200

Adopted by the Human Services Committee
February 11, 2003

2-11-03

PROPOSED AMENDMENTS TO SENATE BILL NO. 2349

Page 1, line 7, replace "1. A person" with "An individual licensed under this chapter"

Page 1, line 13, replace "a person" with "an individual"

Page 1, remove line 16

Renumber accordingly

Date: 02-10-03
Roll Call Vote #: 1

2003 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2349

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Move to accept amendments

Motion Made By Sen. Fischer Seconded By Sen. Brown

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee - Chairman					
Senator Richard Brown - V. Chair.					
Senator Robert S. Erbele					
Senator Tom Fischer					
Senator April Fairfield					
Senator Michael Polovitz					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 02-11-03
Roll Call Vote #: (1)

2003 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2349

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Not Pass

Motion Made By Sen. Polovitz Seconded By Sen Erbele

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee - Chairman	✓				
Senator Richard Brown - V. Chair.		✓			
Senator Robert S. Erbele	✓				
Senator Tom Fischer		✓			
Senator April Fairfield		✓			
Senator Michael Polovitz	✓				

Total (Yes) 3 No 3

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Motion failed

Date: 02-11-03
Roll Call Vote #: 2

2003 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2349

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Amend w/ Jack Macdonald's amendments.

Motion Made By Sen. Fischer Seconded By Sen. Polovitz

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee - Chairman	✓				
Senator Richard Brown - V. Chair.	✓				
Senator Robert S. Erbele	✓				
Senator Tom Fischer	✓				
Senator April Fairfield		✓			
Senator Michael Polovitz	✓				

Total (Yes) 5 No 1

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 02-11-03
Roll Call Vote #: 3

2003 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2349

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass

Motion Made By Sen. Fischer Seconded By Sen. Polovitz

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee - Chairman	✓				
Senator Richard Brown - V. Chair.	✓				
Senator Robert S. Erbele	✓				
Senator Tom Fischer	✓				
Senator April Fairfield	✓				
Senator Michael Polovitz	✓				

Total (Yes) 6 No 0

Absent

Floor Assignment Sen. Fairfield

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
February 12, 2003 12:54 p.m.

Module No: SR-27-2396
Carrier: Fairfield
Insert LC: 38368.0101 Title: .0200

REPORT OF STANDING COMMITTEE

SB 2349: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2349 was placed on the Sixth order on the calendar.

Page 1, line 7, replace "1. A person" with "An individual licensed under this chapter"

Page 1, line 13, replace "a person" with "an individual"

Page 1, remove line 16

Renumber accordingly

2003 HOUSE HUMAN SERVICES

SB 2349

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. SB 2349

House Human Services Committee

☐ Conference Committee

Hearing Date March 12, 2003

Tape Number	Side A	Side B	Meter #
1		x	12.6 - 61.7
Committee Clerk Signature	Sharon Kenfield		

Minutes:

Senator Brown appeared as prime sponsor of the bill stating this has to do with chiropractors and has to do specifically with the educational requirements for spinal manipulation and it has to do with a identifying the minimum of hours, 400 to be exact of class room instruction on spinal manipulation or adjustment and a minimum of 800 hours of supervised training.

Cal Rolfson, Counsel for ND Chiropractic Association appeared in support with written testimony.

Rep. Weisz: Anything in NDCC prohibiting the Board from changing or adopting this? No

Rep. Porter: Was there any discussion amongst the chiropractors in choosing the number of hours rather than just choosing accredited program? Answer: There was some discussion about that except when this bill was patterned after a law that is in the State of TN and they use the 400 hour training, their theory being that it was such an important minimum standard public safety,

that that's there rationale for putting that into law rather than having a mater of educational support.

Jeff Askew, Chiropractor in Bismarck, appeared in support stating untrained and unlicensed people using manipulation is not safe and can be harmful, people will benefit from this bill.

Rep. Price: In some of your quotes you reference from family physicians and yet in the original bill you eliminated the family physician from being under that section, and second adding PT's, was there discussion on the other side, if there is no objection to the physicians as far as the exclusion. Answer: need different scopes of training.

Rep. Price: The second part is because the original bill says a section does not apply to the physicians basically, was there any discussion on just adding the PT's into that? No, because of their lack to training to differential diagnosis.

Dr. Swanson: on the Board of Examiners for Chiropractors stated he doesn't want North Dakota to have less standards than any other state. This bill will set standards for ND Chiropractors.

Rep Porter: Question on Accreditation Process of Chiropractic Schools. Answer: 2 schools accredited.

Rep. Porter: Why we as a State should go higher than what a National Accrediting Standard is in picking the number of hours that we required in ND. Answer: Feels if we don't get up - ND will say our standards are lowered. Some states have already increased theirs and we may fall behind.

Rep. Porter: When picking a set number of hours, by putting these minimums that don't need any accrediting standard, then what do we fall back on as far as explaining this is what we pick?

Answer: These have become the accrediting standard, the other schools have these levels of hours and these have become the accrediting hours to be in compliance with licensure.

Jack MacDonald, ND Physical Therapy Association and the North Dakota Examining Commission for Physical Therapists, appeared in opposition with written testimony.

Jody Dr. Roller, Chair of Physical Therapy at the University of Mary in Bismarck objects to another Board trying to regulate what they are taught and number of hours being taught. Feels they are already regulated.

Jeff Schmidt, PT from Fargo, appeared in opposition with written testimony.

Rep. Wieland: Do you belong to a State Board and if so, do they require continuing education and how many hours annually? Answer: The American Physical Therapists Assoc. and every year we have to take a continuing education course and that is 25 hours every 2 years.

Kevin Axtman: PT practicing in Bismarck appeared in opposition with written testimony.

Jack MacDonald: Stated to look at tab 5 of his testimony which sums up their feelings on this matter.

Closed hearing.

Rep. Kreidt motioned a DO NOT PASS, second by Rep. Niemeier.

Rep. Devlin: Right now they have the authority to put that Education in their right now. I don't think we need to clutter up the law.

Rep. Kreidt: We are looking at the Physical Therapists this time, you could also look at athletic trainers, they do along the same lines, then we are going to be looking an athletic trainer having so many hours, the course they take is either equal or probably above the chiropractor.

Rep. Weisz: Visited with a doctor, he made the point that their whole goal is that if we establish this as public policy instead of within the Board, then this will spread out to everyone else.

Rep. Wieland: I hope this doesn't pass, but will vote against this because the guy who works on my back is a chiropractor.

VOTE: 11 - 2 - 0 Rep. Kreidt will carry the bill.

Date: March 12, 2003
Roll Call Vote #: 1

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2349

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Not Pass

Motion Made By Rep Kreidt Seconded By Rep Niemeier

Representatives	Yes	No	Representatives	Yes	No
Rep. Clara Sue Price - Chair	✓		Rep. Sally Sandvig	✓	
Rep. Bill Devlin, Vice-Chair	✓		Rep. Bill Amerman	✓	
Rep. Robin Weisz	✓		Rep. Carol Niemeier	✓	
Rep. Vonnie Pietsch	✓		Rep. Louise Potter	✓	
Rep. Gerald Uglem	✓				
Rep. Chet Pollert		✓			
Rep. Todd Porter	✓				
Rep. Gary Kreidt	✓				
Rep. Alon Wieland		✓			

Total (Yes) 11 No 2

Absent 0

Floor Assignment Rep Kreidt

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
March 12, 2003 4:49 p.m.

Module No: HR-44-4622
Carrier: Kreidt
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

SB 2349, as engrossed: Human Services Committee (Rep. Price, Chairman) recommends **DO NOT PASS** (11 YEAS, 2 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2349 was placed on the Fourteenth order on the calendar.

2003 TESTIMONY

SB 2349

February 5, 2003

SENATE HUMAN SERVICES COMMITTEE
SB 2349

SENATOR LEE AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm appearing here today on behalf of the North Dakota Physical Therapy Association and The North Dakota State Examining Committee for Physical Therapists. We don't object to the purpose of SB 2349, but we are concerned that it may add confusion as to who is authorized to perform spinal manipulation.

Any licensed North Dakota health care provider under law is authorized to perform the functions under their scope of practice. However, the last line of this bill seems to exclude only physicians from the provisions of the bill, thereby implying that other health care providers are included. Additionally, physicians are already exempt from the provisions of Chapter 43-06 under §43-06-02 (4), NDCC.

Therefore, we would respectfully request the amendment below. The amendments limit the provisions of this bill to chiropractors.

If you have any questions, I will be happy to try to answer them. THANK YOU FOR YOUR TIME AND CONSIDERATION.

PROPOSED AMENDMENTS TO SB 2349

Page 1, line 7, after "person" insert "licensed under chapter 43-06"

Page 1, delete line 16

Renumber accordingly

LEGISLATOR FACT SHEET

Joint manipulation (skilled passive movement to a joint) has always been part of the practice of physical therapy. Even though manual therapy techniques including joint manipulation and joint mobilization have been within the scope of physical therapy practice since its inception, the chiropractic profession continues to challenge, interfere with, and attempt to restrict the physical therapists' practice of manual therapy. Following is a list of facts related to manipulation and its use by physical therapists:

Manipulation Defined

- The *Guide to Physical Therapist Practice* defines mobilization/manipulation as a manual therapy technique comprising a continuum of skilled passive movements to the joints and/or related soft tissue that are applied at varying speeds and amplitudes, including small amplitude/high velocity therapeutic movement.

- Dorland's Medical Dictionary defines manipulation as: "1. Skillful dexterous treatment, as by hand. 2. In physical therapy, the forceful passive movement of a joint beyond its active limit or motion.[2]

Manipulation Facts

- Manipulation is not exclusive to any specific profession.

- Physical therapists have historic experience in the use of manipulation; the literature supporting the use of manipulation by physical therapists dates back to 1928.

- "There is no evidence that physical therapists utilizing manipulative procedures produce a greater risk to the public's health." (Karl Kranz, DC, Dept. of Research & Statistics, American Chiropractic Assoc.)

- Maginnis and Associates and Kirke-Van Orsdel (two of the nation's largest physical therapy liability insurers) found no evidence of higher claims loss due to physical therapists utilizing manipulative procedures. [Appendix A]

- The American Medical Association (AMA) Common Procedural Terminology (CPT) code for use by physical therapists reads "manual therapy techniques (mobilization/manipulation, lymphatic drainage, manual traction)."[3]

- *The Normative Model of Physical Therapist Professional Education* includes manipulation as course content and skill acquisition components of physical therapist education. The Normative Model is used by developing and established physical therapy programs in determining necessary course content for the physical therapy curriculum.[4]

- "Manipulation and mobilization have existed in physical therapy to some degree from the beginning." Quote from Karl C. Kranz, DC, Dept. of Research and Statistics, American

Chiropractic Association.

- Mobilization and manipulation are an integral part of the direct interventions listed in the *Guide to Physical Therapist Practice* under the section entitled, "Manual Therapy Techniques," (p. 3-9). The *Guide* describes physical therapist scope of practice.

- AHCPR Clinical Practice Guideline # 16 Acute LBP in Adults, defines manipulation as "manual therapy in which loads are applied to the spine using short or long lever methods. The selected joint is moved to its end range of voluntary motion followed by application of an impulse loading" with goals of symptom relief and improved function.

Manipulation was not designated as being the domain of any specific profession or group of practitioners. Clifton Gaus, Administrator for the Agency for Health Care Policy and Research, Department of Health and Human Services in a response to an inquiry by the Canadian Physiotherapy Association said, "The ACA (American Chiropractic Association) advertisement enclosed with your letter clearly suggests that the clinical practice guideline on Acute Low Back Problems in Adults, developed with support from this Agency, represents our endorsement of chiropractic care and promotes spinal manipulation as a "preferred treatment" for acute low back pain. I assure you that this was not our intent." He went on to point out that "The (AHCPR) panel did not ...identify any specific group of health care professionals or specialists as being qualified to perform this procedure."

It should also be noted that the best studies cited by the AHCPR panel regarding the effectiveness of manipulation were studies in which the manipulation was performed by physical therapists as well as several other non-chiropractic physicians. Two of the studies* were authored by physical therapists.

*Brodin H., "Inhibition-Facilitation Technique for Lumbar Pain Treatment," *International Journal of Rehabilitation Research*, 1984, 21:272-282.

*Farrell JP, Twomey LT, Acute Low Back Pain. Comparison of Two Conservative Treatment Approaches, *Medical Journal Australia*, 1982, February 20, 1 (4): 160-4.

Manipulation Education and Training Among Health Professionals
(In hours of classroom/lab study)

School#	DC	MD	DO	PT
1	885	0	163	0
2	750	0	95	0
3	696	0	X	0
4	680	0	125	0
5	612	0	X	0
6	600	0	X	0
7	600	0	X	0
8	525	0	–	0
9	495	–	–	0
10	480	–	–	0
11	450	–	–	–
12	405	–	–	–
13	390	–	–	–
14	330	–	–	–

Basic Science Compnrisons Between Licensed Health Providers

Subject	M.D.	D.C.	P.T.
Anatomy/Embryology	215	456	171
Physiology	174	243	87
Pathology**	507	296	15
Chemistry	100	161	0
Microbiology	145	145	0
Diagnosis***	113	408	0
Neurology	171	149	132
X-Ray	13	271	0
Psychology/Psychiatry	323	56	45
Obstetrics/Gynecology	284	66	0
Orthopedics	2	168	0
Other Required Subjects	2201	2066	1986
Total Classroom Requirements	4248	4485	2436

"Robert Schulte, PT, M.B.A., SCS, ACSM" <rschulte@umary.edu>

To: <jlee@state.nd.us>
cc: <brown.richard.l.n@att.net>, <afairfie@state.nd.us>, <tfischer@state.nd.us>, <Michael_polovitz@und.ndak.edu>
Subject: Senate Bill No. 2349

02/07/2003 10:48 AM
Please respond to "Robert Schulte, PT, M.B.A., SCS, ACSM"

Dear Senate Human Services Committee,

I want to briefly communicate my opposition to Senate Bill No. 2349. As a health care provider and academician, I have grave concerns regarding a chiropractic initiative to mandate manipulation provisions.

Typically, the purpose of this legislation is to limit consumers' access to and choice for manipulation to chiropractors, which simply is not in consumers' best interest. Consumers should have the ability to select from all providers with the education and clinical ability to perform manipulative interventions, including physical therapists.

Manual manipulation, including manipulation of the spine, is a long-standing part of physical therapist practice, for which physical therapists have billed and been paid by Medicare for years. The manual therapy services provided by physical therapists are included under CPT codes in the 97000 series, which do not refer to "subluxation."

Furthermore, I instruct these manipulation / manual therapy techniques to students in our professional program at the University of Mary and utilize these techniques in my professional practice.

I recommend that the committee either adopt Jack McDonald's amendments to SB 2349 that restricts its provisions to chiropractors, or in the alternative, to give the bill a do not pass as legislation that is simply not needed at this time.

Please extend my concerns to the other committee members and do not hesitate to contact me if you have questions.

Sincerely,

Bob Schulte

Dr. Robert Schulte, PT, D.Sc., M.B.A., SCS, ACSM-ES®
Assistant Professor / Board Certified Clinical Specialist
Division of Human Performance Science / Physical Therapy
University of Mary
Office: 701-255-7500 x 8204
Fax: 701-255-7687
Email: rschulte@umary.edu <mailto:rschulte@umary.edu>

"Reed Argent"
<argent@ndak.net>
02/07/2003 12:12 AM

To: <jlee@state.nd.us>
cc:
Subject: Re: SB 2349 -- Do Not Pass

Dear Senator Lee:

I am emailing you to voice my opposition to SB 2349 as this bill would infringe upon my scope of practice as a physical therapist. We as physical therapists have been trained in manipulation and it has been included in our scope of practice for the past 45 years. Throughout that time there has never been a single complaint or problem involving the improper application of this technique. Physical Therapists undergo three-four years of undergraduate training and two to three years of post-graduate training in such areas as diagnosis, anatomy, histology, physiology, biomechanics, kinesiology, neuroscience, pharmacology, pathology, the behavioral sciences, clinical science systems and interventions.

This is a classic example of a turf battle. In North Dakota, state law and state rules and regulations carefully set out the scope of practice for health care professionals. There are often some areas of overlap - such as ultra sound, exercise, hot and cold treatment modalities and even manipulation. In each of these instances, the various professions practice these procedures within the limits of their scope of practice. We as physical therapists know a lot about exercise but do not claim to have exclusive rights to it so therefore we do not believe chiropractors should have exclusive rights to spinal manipulation.

In this bill, the chiropractors want to regulate all the other health care professionals. They should instead concern themselves with their practice and training. If they feel other health care professionals are practicing improperly, then they can follow regular procedures already established in state law and file complaints with the appropriate licensing and disciplinary boards.

I urge you to either adopt Jack McDonald's amendments to SB 2349 that restricts its provisions to chiropractors, or in the alternative, to give the bill a do not pass as legislation that is simply not needed at this time.

Thank You For Consideration Of This Matter,

Reed Argent, PT
2556 Belview Drive
Minot, ND 58701

Manipulation: A Covered Physical Therapist Service

With the filing of a "Stipulation of Dismissal," Medicare's recognition of physical therapists as providers of manipulation services is no longer under challenge. The Federal Government and the American Chiropractic Association (ACA) have agreed to the dismissal of Count II of the ACA's suit (*American Chiropractic Association, Inc v Tommy G Thompson, Secretary of Health and Human Services*), which sought a ruling from the Court that physical therapists could not perform manual manipulation of the spine as a Medicare covered service.

With dismissal of Count II, the government's long-standing policy of treating manipulation of the spine provided by a physical therapist as a Medicare covered service remains in effect. This policy frequently was affirmed in the Government's pleadings to the Court. In one instance, the Government wrote that "a physical therapist may provide, and be reimbursed by Medicare for, the services of manipulative treatment of the spine as long as that service is appropriate and within the scope of the physical therapist's license." And in another, while affirming that manipulation of the spine *to correct a subluxation* is a physician service, the government went on to say that "this reading of the statute does not, however, preclude physical therapists from providing whatever services they are authorized to perform under the scope of their licenses."

The ACA based its decision to file the stipulation of dismissal on the publication of a revised version of the Centers for Medicare and Medicaid Services' (CMS) Operational Policy Letter #23. This Letter states that "the statute specifically references manual manipulation of the spine *to correct a subluxation* as a physician service" (emphasis added) and that Medicare+Choice organizations "may not use non-physician physical therapists for manual manipulation of the spine *to correct a subluxation*" (emphasis added). The letter concludes with the statement: "Medicare+Choice organizations may continue to use physical therapists to treat enrollees for conditions not requiring physician services." On several occasions CMS representatives have confirmed that these physical therapist treatments include manipulation of the spine services, precisely as was stated in the Government's submissions to the Court.

In light of the dismissal of Count II, APTA withdrew its motion to intervene in the lawsuit because ACA is no longer seeking relief that would adversely affect physical therapists. APTA has reserved its right to ask the Court for permission to file an amicus brief on the remaining issues before the court if future developments warrant that action.

With this somewhat surprising turn of events, another challenge to the right of physical therapists to manipulate the spine falls quietly by the wayside.

Update

APTA Update on CMS Operational Policy Letter

Last week we notified you of a recent ruling from the Centers for Medicare and Medicaid Services (CMS) concerning manual manipulation of the spine to correct a subluxation.

Manual manipulation, including manipulation of the spine, is a long-standing part of physical therapist practice, for which physical therapists have billed and been paid by Medicare for years. The manual therapy services provided by physical therapists are included under CPT codes in the 97000 series, which do not refer to "subluxation."

The CMS Operational Policy Letter addressed the question of "which practitioners are authorized by law to perform manual manipulation of the spine to correct a subluxation as a Medicare-covered service." The CMS letter concludes that Medicare+Choice organizations "may not use non-physician physical therapists for manual manipulation of the spine to correct a subluxation." The CMS letter reasons that, because the Medicare law refers to manual manipulation of the spine to correct a subluxation only in a section that defines a "physician" for purposes of the statute, manual manipulation of the spine to correct a subluxation is "a physician service," and thus Medicare+Choice organizations may use only "physicians", including chiropractors, and not physical therapists, to provide the service. (Chiropractors are considered "physicians" under the Medicare statute for the limited purpose of providing manual manipulation of the spine to correct a subluxation).

APTA notes that the CMS Operational Policy Letter applies only to Medicare+Choice, and not to traditional fee-for-service Medicare. More importantly, the CMS Operational Policy Letter expressly applies only to manual manipulation of the spine to correct a subluxation. Consequently, APTA believes that physical therapists may continue to furnish manual manipulation of the spine for any other purpose to Medicare+Choice beneficiaries, so long as physical therapists practice within the scope of their state licensure. Moreover, since the CPT codes for manual manipulation currently used by physical therapists do not reference "subluxations," the CMS Operational Policy Letter does not restrict in any fashion the ability of physical therapists to furnish the services they have historically furnished to Medicare+Choice beneficiaries, or the ability of physical therapists to bill for those services as before. In short, APTA views the CMS Operational Policy Letter as a clarification of pre-existing policy, rather than a change in policy that would affect in any way the scope of physical therapist practice under Medicare+Choice.

Based on preliminary discussions, it is APTA's understanding that CMS and HHS officials do not disagree with APTA's position on this issue. CMS officials have indicated that the OPL is limited in scope and only applies to manual manipulation of the spine to correct a subluxation. Further, CMS/HHS continues to oppose the lawsuit brought by the American Chiropractic Association (ACA), in which the ACA seeks (a) to declare chiropractors the exclusive providers of manual manipulation services to correct a subluxation; and (b) to prohibit physical therapists from providing any manual manipulation of the spine services to Medicare+Choice beneficiaries. APTA has sought to intervene in the lawsuit, and has filed briefs opposing the ACA's substantive arguments. The case is pending.

"First Choice Physical Therapy" <fopt@minot.com>

02/07/2003 02:37 PM

To: <jlee@state.nd.us>
cc:
Subject: SB2349

Senator Lee, I am writing in regards to SB2349. This bill is an attempt by the chiropractors to regulate another profession. The Chiropractic Association tried this on a federal level last year with HCFA proposing that only chiropractors should be reimbursed for mobilization/manipulation in the Medicare system. This was soundly defeated but we are now seeing the attempt made at a state level. Physical Therapists have been trained in manipulation and it has been included in our scope of practice for the past 45 years. Throughout that time there has never been a single complaint or problem involving the improper application of this technique. The chiropractors should concern themselves with their practice and training. If they feel other health care professionals are practicing improperly, they can follow regular procedures already established in state law. I urge you to give the bill a "do not pass" as the legislation is simply not needed at this time.

Karen Rasmusson, MPT

"Joellenn Roller" <jroller@bis.midco.net>
02/08/2003 09:54 AM

To: <jlee@state.nd.us>
cc:
Subject: Senate Bill 2349

Dear Senator Lee,

I am writing to you about Senate Bill 2349 that would in effect put limits on Physical Therapy Practice in the State of North Dakota. I am especially concerned about the testimony provided to you about this bill as it relied on nonexistent research and many false hoods to make its point. Physical Therapists are well trained-and becoming moreso at both UND and the University of Mary as both programs transition to a Doctorate degree which involves lengthening our curricula. Written testimony about this bill indicated that physical therapists get no training in orthopedics and radiology (among others). I can assure you that physical therapist students receive hundreds of hours of orthopedic related training including the scientific basis and the hands on techniques for the manipulation procedures spoken of by chiropractors. Our physical therapy practices are becoming increasingly evidenced-based where we demand that our students explore the literature and provide a scientific rationale for the techniques they are using as well as to determine the effectiveness on patients. Safety is highly stressed in any physical therapy curriculum and physical therapists have an exemplary record of both effectiveness of our treatments and safety for our patients. Differential diagnosis is part of our every day practice.

The bill brought forth by chiropractors is a thinly disguised effort at limiting the practice of physical therapists under the guise of patient safety. I urge you to accept the amendment as brought forth by Jack McDonald, NDPTA lobbyist.

Thank you for your consideration in this matter.

Dr. Jodi Roller, PT, Program Director
University of Mary Program in Physical Therapy
355-8183

"Justin Berry" <justberry@hotmail.com>
02/09/2003 04:20 PM

To: jlee@state.nd.us
cc:
Subject: SB 2349

Dear Senator Lee,

My name is Justin Berry and I am a physical therapist residing and practicing in Grand Forks. I am writing regarding my concerns with senate bill 2349. This bill should be amended so it does not include physical therapists, or it should be killed.

Manipulation is not exclusive to chiropractic. Physical therapists have historic experience in the use of manipulation. It is an integral part of the direct interventions listed in the Guide to Physical Therapist Practice, which describes physical therapist scope of practice.

According to an underwriter's review of approximately 800 cases from Healthcare Providers Service Organization, there was no evidence that indicated physical therapists present a risk factor relative to manipulation. Also, Maginnis and Associates and Kirke-Van Orsdel, two of the nation's largest physical therapy liability insurers, found no evidence of higher claims loss due to physical therapists utilizing manipulative procedures.

The Normative Model of Physical Therapist Professional Education specifically includes manipulation as course content and skill acquisitioncomponents of physical therapist education. The Normative Model is used by developing and established physical therapy programs in determining necessary course content for the physical therapy curriculum.

If you have any questions, please feel free to contact me.

Sincerely,
Justin Berry, MPT
2299 South 34th St. #18
Grand Forks, ND 58201
(701)-775-6614

"Judy Bahe" <jbahe@bis.midco.net>

02/09/2003 08:29 PM

To: "Thomas Fisher" <tfisher@state.nd.us>, "Michael Polovitz" <mpolovitz@state.nd.us>, "Robert Erbele" <rerbele@state.nd.us>, "Ralph Kilzer" <rkilzer@state.nd.us>, "Tim Mathern" <tmathern@state.nd.us>, "Judy Lee" <jlee@state.nd.us>

cc:

Subject: SB 2349: Amend or Kill

Dear Senate Health Committee Members -

I am writing to ask you to either kill or amend SB 2349, which has specific requirements for persons performing spinal manipulation. I am a physical therapist here in Bismarck. Manipulation is not exclusive to chiropractic practices. There are many physical therapists who have received formal training and are competent in performing spinal manipulation. It is an integral part of the direct interventions provided by physical therapists as listed in the Guide to Physical Therapist Practice, where the scope of practice for physical therapy is described.

Additionally, manipulation is specifically included as course content and skill acquisition in the education programs for physical therapists. The Normative Model of Physical Therapist Professional Education is used by developing and established physical therapy programs in determining necessary course content. Manipulation is a component that is specifically listed.

Finally, there is no evidence that indicated physical therapists present a risk factor relative to manipulation. This is according to an underwriter's review of approximately 800 cases from Healthcare Providers Service Organization. Also, Maginnis and Associates and Kirke-Van Orsdel, two of the nation's largest physical therapy liability insurers, have found no evidence of higher claims loss due to manipulation techniques provided by physical therapists.

I am requesting that you either kill SB 2349 or amend it so the hours of classroom instruction and the hours of clinical training in a chiropractic clinic to perform manipulation apply only to chiropractors and not to physical therapists.

Thank you for your time and consideration and hopefully your understanding and support for physical therapists in this matter.

Judy Bahe, MPT

"JEFF WOLD" <jwold@cableone.net >

02/09/2003 10:10 PM

To: <jlee@state.nd.us>
cc:
Subject: Opposition to SB 2349

To: Judy Lee, Chairman

I am a physical therapist writing to you to express my concerns about SB 2349 which would limit spinal manipulation to those persons having 400 hours of classroom instructions and 800 hours of clinical training in spinal manipulation in a chiropractic clinic.

As a physical therapist with 30 years of experience of which the last 23 years have been in Fargo-West Fargo area I have been trained in spinal manipulation and many of my continuing education classes have been in spinal care to include manipulation. Many of the treatments used in physical therapy and chiropractic overlap such as ultrasound, exercises, stretching, hot and cold treatments and manipulation.

There are many changes taking place in all of health care. I would not like to see spinal manipulation limited only to chiropractics. This would not help the general public and in fact limit the public to only one type of health care provider who would provide spinal manipulation. In 1995 the chiropractors of South Dakota introduced similar legistration to limit spinal manipulation to their profession and it was defeated.

I would urge you not to pass this legislation all together or adopt an amendment to SB 2349 that restricts these standards to only chiropractors.

Thank you for your consideration,

Sincerely,

Jeff Wold
4461 Oakcreek Drive S.W.
Fargo, ND 58104

Jay Fischer
<jfischer@btinet.net>

02/09/2003 10:18 PM
Please respond to
jfischer

To: jlee@state.nd.us, tmathern@state.nd.us, rkilzer@state.nd.us, rerbele@state.nd.us, mpolovit@state.nd.us, tfisher@state.nd.us
cc:
Subject: SB 2349

Dear Senator,

We are writing to express our concern regarding SB 2349.

SB 2349 requires that a person must have 400 hours of classroom instruction in spinal manipulation and 800 hours of clinical training in spinal
manipulation in a chiropractic clinic to perform manipulation!

We oppose this bill, as written, for the following reasons:

#1. Manipulation is not exclusive to chiropractic. Physical therapists have
historic experience in the use of manipulation. It is an integral part of
the direct interventions listed in the Guide to Physical Therapist Practice,
which describes physical therapist scope of practice.

#2. According to an underwriter's review of approximately 800 cases from
Healthcare Providers Service Organization, there was no evidence that indicated physical therapists present a risk factor relative to manipulation. Also, Maginnis and Associates and Kirke-Van Orsdel, two of
the nation's largest physical therapy liability insurers, found no evidence of higher claims loss due to physical therapists utilizing manipulative
procedures.

#3. The Normative Model of Physical Therapist Professional Education specifically includes manipulation as course content and skill acquisition
components of physical therapist education. The Normative Model is used

by developing and established physical therapy programs in determining necessary course content for the physical therapy curriculum.

We strongly feel that this bill needs to be amended to exclude Physical Therapists or should not pass at all. We hope you will support us and our profession.

Sincerely,

Jay Fischer, PT
Cathy Fischer, PT

Mark Brenner <MarkBrenner@meritcare.com>

To: "'jlee@state.nd.us'" <jlee@state.nd.us>
cc:
Subject: SB 2349

02/10/2003 10:49 AM

Honorable Senator Judy Lee,

I ask that you do not pass SB 2349 in its current form, but would support the bill with the proposed amendments by Jack McDonald that restricts its provisions to chiropractors.

I have been an outpatient physical therapist at MeritCare in Fargo for 14 years and regularly utilize spinal manipulation in my treatment of patients. Obviously, I have the educational and clinical background to perform this treatment technique or I would not be utilizing it on my patients. My patients have never had an adverse affect from spinal manipulation and I see no reason why another health care professional should be trying to regulate my ability to function as a physical therapist. We have state rules and regulations as well as licensing boards to take care of practice issues.

Thanks for your time in this important matter and thank-you for your willingness to serve our great state in the legislature. Please feel free to contact me if you have any questions or concerns. Thanks again.

Mark Brenner, PT
Coordinator of Outpatient Physical Therapy
MeritCare Broadway Health Center
(701) 234-6738 or 234-6735
800-821-2232
Fax (701) 234-7452
Pager 3709

MOBILIZATION AND MANIPULATION

UNDERSTANDING THE DIFFERENCE

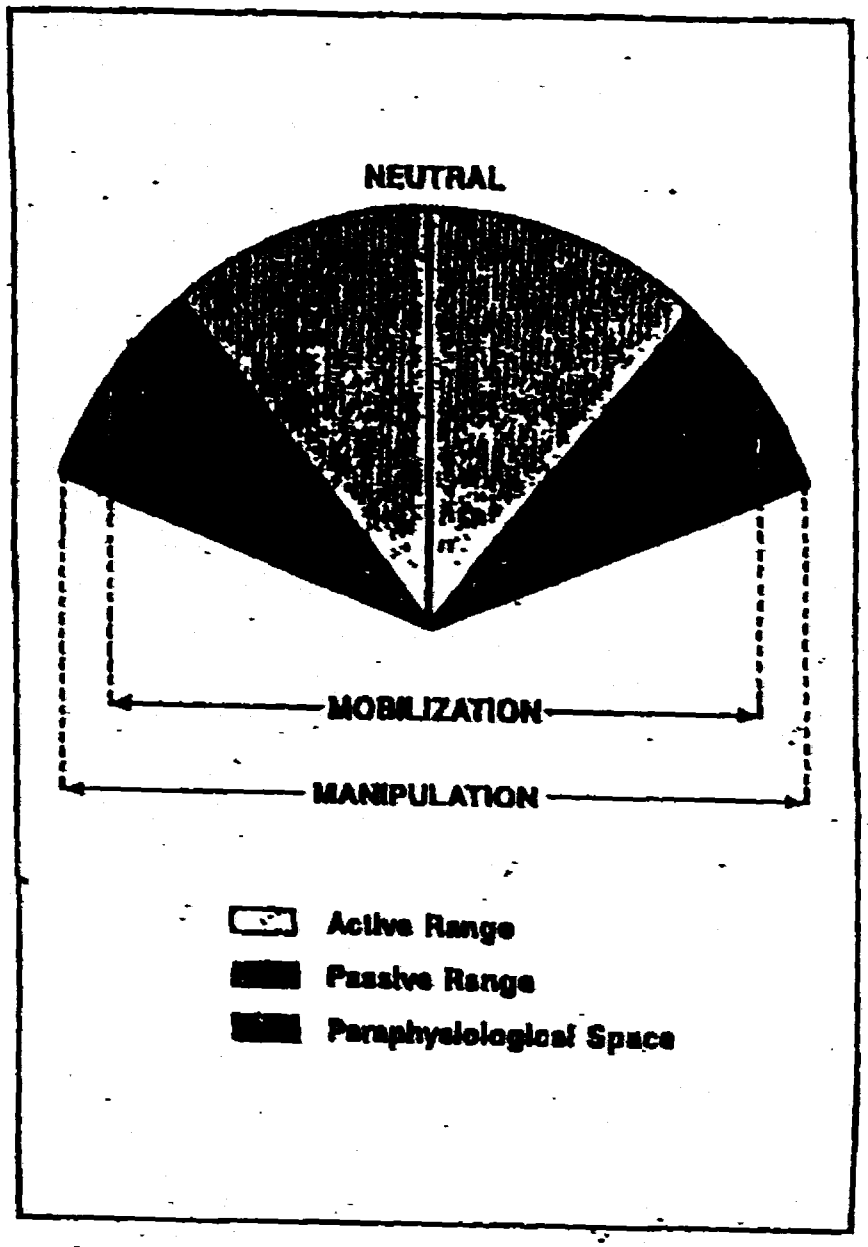
Although mobilization and manipulation sound similar, there is a tremendous difference in the two procedures and the expertise required to perform them. The illustration will help assist in understanding the two terms.

MOBILIZATION

The light shaded area on each side of the neutral line represents the range of movement a patient can make without assistance. This is called the active range of motion. The passive range of motion is the range of movement that can be accomplished with assistance and is represented by the medium shaded area. At the end of the passive range, the practitioner will feel a resistance which is known as the elastic barrier. All movement up to this point is defined as mobilization.

MANIPULATION

Manipulation is a skilled maneuver during which the joint is carried beyond the normal passive range of movement without exceeding the boundaries of anatomical integrity. This movement is accomplished with a brief, sudden, and carefully administered "impulsion" and is usually accompanied by an audible sound. Movement across the elastic barrier results in manipulation which is represented in the illustration by the dark shaded area.



43-26-01. Definitions. In this chapter, unless the context or subject matter otherwise requires:

3. "Physical therapy" means the art and science of a health specialty concerned with the prevention of disability and the physical rehabilitation for congenital or acquired disabilities resulting from, or secondary to, injury or disease. The practice of physical therapy means the practice of the health specialty, and encompasses physical therapy evaluation, treatment planning, instruction, and consultative services, including:
   a. Performing and interpreting tests and measurements as an aid to physical therapy treatment.
   b. Planning initial and subsequent treatment programs, on the basis of test findings.
   c. Administering treatment by therapeutic exercise, neurodevelopmental procedures, therapeutic massage, mechanical devices, and therapeutic agents which employ the physical, chemical, and other properties of air, water, heat, cold, electricity, sound, and radiant energy for the purpose of correcting or alleviating any physical or mental condition or preventing the development of any physical or mental disability.

43-25-02. Definitions.

2. "Massage" means the scientific and systematic manipulation of the soft tissues of the human body through any manual or mechanical means, including superficial hot and cold applications, hydrotherapy, reflexology, and the use of salts or lubricants. "Massage" does not include diagnosing or treating diseases, manipulating the spine or other joints, or prescribing or administering vitamins.

The Efficacy of Spinal Manipulation

Perhaps the first issue to be addressed regarding the application of any therapeutic intervention is that of efficacy, or simply put, can it be of benefit. If a treatment is of no potential benefit, it should not be an accepted part of a patients therapeutic options regardless of its cost or safety. Spinal manipulation has gone from an unstudied treatment based on contemporary scientific methods only twenty-five years ago to perhaps the most thoroughly examined treatment currently for back pain. Scott Haldeman DC, MD, PhD, a neurologist at the University of California and a past president of the prestigious North American Spine Society, pointed this out in a summary of the research status of spinal manipulation for back pain.(1) Dr. Haldeman commented that there are currently 54 published prospective research trials which examined spinal manipulation with several others in progress. No other treatment has been subjected to such research scrutiny.

Dr. Haldeman summarized that spinal manipulation has been found to consistently outperform the medical therapies to which it has been compared including physical therapies, bedrest, exercises, medications and placebos. He summarized his analysis with the comment "Spinal manipulation should serve as the model for the proponents of other back pain treatments.....Outcomes research has led to the legitimization of a treatment modality that was regarded in the medical community as quackery twenty years ago."

While the research on the efficacy of all treatments for neck pain is less abundant than for back pain, the results are similar showing that spinal manipulation and mobilization are more supported by outcomes research than all other forms of typical medical treatment.(2) A common condition related to disorders of the neck, that of headache, is another common condition for which spinal manipulation of the neck is frequently used. Peter Rothbart, MD, the current president of the North American Cervicogenic Headache Society has talked of the importance of the neck in causing headache, "We've been able to put together a scientific explanation of how the neck structures cause headaches..... chiropractors have been saying this for years..... They (chiropractors) were right."

Researchers recently published the results of a clinical trial comparing spinal manipulation to medication in headache sufferers. Manipulation proved to be significantly more beneficial over long term follow-up and was associated with fewer side effects.(3) Several other research efforts are underway and spinal manipulation will become one of the more frequently used forms of treatment in the huge population of headache patients.

Treatment Safety

The issue of safety and spinal manipulation has been examined by unobjective analysis and political maneuvering. Only in the past five to ten years have objective

analyses been done. This process has been stimulated by the considerable recent interest in the therapeutic value of spinal manipulation which has greatly increased the objective scientific examination of every aspect of this type of treatment. Few medical scientists question the safety of spinal manipulation of the lumbar spine or lower back. The best examination of the complication rate associated with lumbar spine manipulation has been a statistical evaluation of the reported incidence of cauda equina syndrome secondary to this treatment.(4) Cauda equina syndrome involves loss of function of the legs, bowel and bladder and is caused by compression of the lower spinal cord by herniated disc material. In a thorough evaluation of the medical literature from 1911 to 1989, only twenty-six cases were found to ever have been reported. Interestingly, sixteen of these cases were reported during manipulation under anesthesia, a procedure that was briefly popular during the 1960s and 1970s with a small group of medical practitioners. Perhaps as few as ten thousand of these procedures were performed.

Only ten cases of cauda equina syndrome have ever been recorded during typical office based spinal manipulation. It is estimated that the rate of this complication is approximately 1 per 100,000,000. For a point of reference, lumbar spine surgery has a complication rate for neurologic injury of approximately 1 per 333 operations.(5) In an editorial discussion of the relative safety of lumbar spine manipulation, Shekelle recently summarized that the reported neurologic complication rate for this procedure is less frequent than that during general anesthesia by a factor of 10,000 times.(6)

It is uncertain if the significantly higher rate of complication during manipulation under anesthesia reflects the variations from the normal circumstances under which this treatment is typically given or if it reflects the proficiency of the providers. As is discussed under manipulation of the cervical spine or neck, training and proficiency of the provider seems to be an important factor.

The safety issue regarding manipulation of the cervical spine or neck produces similar results. The most significant potential complication is that of stroke caused by injury to the vertebral artery. Extensive analyses of this procedure have all concluded that this complication is extremely rare occurring in less than 1 per 1,000,000 procedures. *The Backletter* recently examined the comparative complication rates for different treatments for the cervical spine or neck.(7) The injury to the central nervous system during neck surgery is approximately 10,000 times greater than similar complications during manipulation. The death rate from these complications is 30,000 times more common with cervical spine surgery compared to those with spinal manipulation.

Perhaps most often, spinal manipulation will serve as an alternative to anti-inflammatory medications in the treatment of the neck. Several serious complications from these medications occur with much greater frequency than do the complications of manipulation. Serious bleeding of the gastrointestinal tract secondary to the use of anti-inflammatory medications is reported to occur in from one to three patients per 1000 depending on age.(7) The use of these medications increases the risk of acute kidney failure from the normal population risk of 2 persons per 100,000 to over 4 per

100,000.(8)

Looking at the combined benefit/risk profile of spinal manipulation suggests that it has perhaps one of the best benefit to risk ratios of all treatments given to patients with spinal disorders. This record, however, appears to be significantly different based on the training and qualifications of the provider performing spinal manipulation. In the most comprehensive evaluation of the scientific literature regarding stroke secondary to manipulation of the cervical spine, Terrett found that while health care providers other than chiropractors (ie: medical physicians, osteopaths and physical therapists) have performed only about 6% of all spinal manipulation, they have accounted for 27% of the complications.(9) This suggests that, even though the overall complication rate for cervical spine manipulation is exceptionally low, it is disproportionately higher for manipulation performed by a health care providers other than chiropractors. The rate is approximately six times greater for other providers versus chiropractors. This opinion has been shared by other investigators. Manga performed an extensive evaluation of the literature on lumbar spine manipulation and similarly concluded that it appears that this procedure is safer when performed by chiropractors versus other providers.(10)

In an elaborate discription of the factors that control the loads or force introduced into the spine during manipulation, Triano suggests that proper manipulation involves a complex knowledge of the technique combined with considerable skill.(11) This skill has been found to be dependant on both provider training and experience. Their testing of the biomechanical qualities of a manipulation procedure has shown differences in the time/force parameters of manipulation of as much as 70% between expert an novice practitioners. This suggests a strong correlation between the quality of manipulation and the practitioners training/experience.

The true issue does not seem to be that spinal manipulation should be performed only by chiropractors but rather only by those with a similar level of training which seems to be associated with a reduced complication rate. These statistics suggest that, while manipulation is a very safe alternative for patients with spinal disorders, it is only so when this procedure is performed by a practitioner with extensive training in the field of spinal manipulation and by one who performs this procedure on a frequent enough basis to maintain proficiency. The contrast between the safety statistics of chiropractors versus other providers should suggest that the chiropractic training standards for spinal manipulation should be the standard for all practitioners providing this service.

TESTIMONY

BY
CALVIN N. ROLFSON
ON BEHALF OF
NORTH DAKOTA CHIROPRACTIC ASSOCIATION
IN FAVOR OF
SENATE BILL 2349

My name is Cal Rolfson, I am an attorney from Bismarck. I am the legislative counsel for North Dakota Chiropractic Association. I appear here in support of Senate Bill 2349.

My purpose will be to review with you the specifics of the Bill, followed by some general comments regarding the procedure of spinal manipulation. Following my testimony, doctors of chiropractic licensed in North Dakota will expand on this issue for you, since that is directly within their expertise.

North Dakota is not the first state to have considered legislation similar to Senate Bill 2349. Other states with such public policy statements include the states of Tennessee, Virginia, North Carolina, West Virginia, and others. What prompted many states to purpose legislation of this nature was the desire by some allied health professionals, including some physical therapists, to do spinal manipulation, believing it is within the scope of their practices. In some of those states, greater

adverse results to patients have occurred when physical therapist, without adequate training and experience, engaged in spinal manipulation of a patient. In some of those states, physical therapists were even billing insurance providers for "chiropractic" services in order to receive payment for their spinal manipulations.

This prompted the North Dakota Chiropractic Association to bring this to the attention of law makers in North Dakota to help eliminate any potential adverse impact to the citizens of North Dakota because of untrained or persons doing spinal manipulation. I will explain a bit more about that after reviewing the Bill.

Essentially, this Bill would better fit as a general addition to Title 43 of the North Dakota Century Code, rather than a specific addition to the Chiropractic Chapter found in Chapter 43-06. I will offer an amendment to do that at the close of my testimony.

This Bill does not intend to restrict anyone from practicing spinal manipulation or spinal adjustment who may have the appropriate training. It is intended as a pro-active approach to you as policy makers and an effort to allow you to take a position to protect our citizens from the trends seen in other states where some health professionals, other than physicians and chiropractors, engage in spinal adjustment and place their patients at potentially serious risk of harm.

Lines 1 through 12 of the Bill, state that no person (whether chiropractor,

physical therapist, massage therapist or anyone else) may perform a spinal manipulation or spinal adjustment without:

1. The ability to differentially diagnose the need for such a procedure;
2. Receiving a minium of 400 hours of classroom instruction in spinal manipulation or spinal adjustment;
3. Practicing a minium of 800 hours in supervised clinical training at facilities where such diagnosing and spinal manipulation procedures are the primary method of treatment.

In other words, the Bill states that unless you have adequate classroom hours, diagnosing skills and adequate clinical training at facilities that specialize in such procedures, you cannot do spinal manipulation or spinal adjustments.

Lines 12 through 15 of the Bill essentially define spinal manipulation and spinal adjustment as interchangeable terms that identify the skillful and beneficial treatment where the practitioner uses direct thrust as a technique to move a patient's spinal joint beyond its normal range and is done without exceeding the spinal limits of anatomical integrity. In other words, spinal manipulation or spinal adjustment is specifically distinguished from massage or mobilization. The last line of the Bill specifically excludes medical doctors and doctors of osteopathy who are licensed under Chapter 43-17 of the North Dakota Century Code.

Most M.D.s and D. O.s would not do spinal manipulation in their practices, although some physiatrics may do so within the scope of their practice. Under Chapter 43-17 physicians may have the statutory authority to engage in spinal manipulation within the scope of their practice. Therefore, this Bill would specifically exclude them from the provisions of this Bill and would allow them to do spinal manipulation or spinal adjustment within the scope of their standards of practice.

It is important to understand what spinal manipulation entails. Attached to my testimony is graphic that helps explain spinal manipulation. Please refer to that. Although mobilization and manipulation sounds similar, there is a tremendous difference in the two procedures and the expertise required to preform them. Referring to the attached illustration, the light sheeted area on each side of the neutral line represents the range of movement a patient can make without assistance. This is call the active range of motion. (If you will take your index finger, hold it up and try to move it back as far as you can on your own, that is the active range of motion of your finger.) The passive range of motion is the range of movement that can be accomplished with assistance and is represented by the medium shaded area. At the end of the passive range, the practitioner will feel a resistence that is known as the elastic barrier. All movement up to this point is defined as

mobilization. Mobilization into this passive range occurs when you take the index finger of your other hand and move your other extended index finger as far back as it can go. That is mobilization.

"Manipulation" is a skilled maneuver during which the joint is carried beyond the normal passive range of movement without exceeding the boundaries of anatomical integrity. The movement is accomplished with a brief sudden and carefully administered thrust that is often (though not always) accompanying by an audible sound. Manipulation is represented by the dark shaded area in the illustration. Beyond manipulation, is the dangerous portion that may subject a patient to injury. Having education, training and experience to know the fine line difference between mobilization and manipulation is the art and science practice by doctors of chiropractic.

There is a movement by the American Physical Therapist Association to eventually seek "doctors of physical therapy" degrees nationally and to permit them to do physical therapy in "all environments" for the patient. (including spinal manipulation) The North Dakota Chiropractic Association has no objection to any healthcare profession that seeks to advance its standard of practice to include spinal manipulation, as long as their educational, clinical, and practice standards are sufficient to safely support such a technical and complex area of patient care.

The one question that I anticipate you will ask is why 400 hours of academic training. The North Dakota Chiropractic Association did a survey of all chiropractic colleges and universities in order to determine the number hours in which spinal manipulation education and training is taught. The attached exhibit demonstrates that the number of hours for chiropractors in their respective colleges and universities ranges between 885 hours and as lows as 330 hours. 400 hours was selected as one of the lowest hours of training in such schools, with only two schools below that level.

Note also that no medical school teaches spinal manipulation and no school of physical therapy teaches spinal manipulation. Some D. O. schools teach a limited number of hours in that category.

From this it can be seen that the only post graduate education that emphasizes spinal manipulation in its educational setting are chiropractic colleges. On the other hand, physical therapy education course materials contain no courses teaching spinal manipulation. I understand that there are some weekend training courses of 18 to 20 hours offered to physical therapist and allopathic physician around the nation that claim to teach some level of proficiency in manipulative therapy.

The next chart attached to my testimony demonstrates the basic science

comparison between licensed health providers (physicians, chiropractors and physical therapists). Note the hours of instruction in the area of physiology, anatomy, and in particular, diagnosing.

Spinal manipulation is increasing in demand and utilization because it has been shown to be highly effective in the treatment of many conditions, including low back pain, headaches, neck pain, shoulder pain, and others. It is also cost effective enjoys an enviable safety record when compared to other possible treatments of the spine, has a high degree of satisfaction among the patient population, and has an extensive body of research to support this utilization.

Statics indicate that when providing spinal manipulation, providers without comprehensive training in the procedure appear to have six times the complication rate when compared to those providers with such training. Spinal manipulation provided by inadequately trained practitioners presents a clear danger to the public. The issue is not that spinal manipulation should be preformed only by doctors of chiropractic, but rather it should be preformed only by those with adequate levels of training.

A reference to the physical therapist Chapter 43-46, NDCC, when compared to 43-6, is indicated on the attached chart. Note that the definition of "physical therapy" in North Dakota does not include any manipulation of the spine. For that

reason, the practice of physical therapy should not be affected by this law, since spinal manipulation is statutorily outside the scope of their practice. Note also the definition of "massage" found in NDCC section 43-25-02, which specifically excludes manipulation of the spine.

Also attached to my testimony is a research analysis prepared by the Virginia Chiropractic Association in 1997 regarding spinal manipulation. I am attaching portions of that research that deals with the issue of efficacy and safety in spinal manipulation. In a nut shell, the national research supporting these conclusions indicates that the safety record of practitioners providing spinal manipulation with the same training and experience as chiropractors results in a six times higher level of safety than any other healthcare professional doing that procedure.

CONCLUSIONS

1. Spinal manipulation is becoming increasingly utilized in healthcare, because of demonstrated efficacy and high public demand.
2. Increase utilization of spinal manipulation is causing concerns about provider training and related safety issues.
3. Spinal manipulation of either the lumbar or cervical spines has an excellent safety record compared to other interventions, including surgery, that may be used in the same patient population.

4. Although spinal manipulation has one of the best benefit/risk ratios of treatments commonly used for spinal disorders, this factor is strongly correlated to and influenced by high provider training and experience.

5. Those providers with the greatest number of hours of specific training and spinal manipulation as related diagnoses have the lowest associated complication rate. Comparative rates for those without comprehensive training in spinal manipulation may be as much as six times higher risk of adverse result.

6. Minimum standards of provider training to perform spinal manipulation are warranted as public policy to ensure adequately public safety, without intruding upon the acceptable standards of practice of any professional.

Attached to my testimony is the recommended amendment that essentially places this law in the general title regulating professions in North Dakota, (Title 43) rather than in the chiropractic chapter.

I urge your favorable consideration of a "do pass" to the Senate Bill 2349.

Calvin N. Rolfson
Legislative Counsel
North Dakota Chiropractic Association
(Lobbyist No. 144)

PROPOSED AMENDMENTS TO SENATE BILL NO. 2349

Page 1, line 2, replace "chapter 43-06" with "title 43"

Page 1, line 2, replace "chiropractic practice" with "educational requirements for spinal manipulation

Renumber accordingly

Introduction –

Chairman Judy Lee, Vice Chairman Richard Brown and members of the Senate Human Services committee, my name is Dr. Paul Ellenbecker. I am a practicing chiropractor of 16 years, and 11 of those years I have served on the Board of Directors of the North Dakota Chiropractic Association. Currently I serve as the Immediate Past President.

I strongly urge your support of Senate Bill # 2349.

The time is right for the passage of such a bill as a public safety statement.

Spinal manipulation is one of the oldest forms of treatment, having been used in the healing arts for centuries. (i.e. Hieroglyphics and ancient Chinese practices.) In 1895, Dr. D. D. Palmer perfected the art and science of spinal manipulation into the profession that we refer to today as chiropractic. In fact, a study by the prestigious RAND Corporation confirmed that chiropractors perform 94% of all spinal manipulations performed in this country, with osteopaths delivering just 4% and medical physicians performing the remaining 2%.

However, in spite of the longevity of this form of treatment, it has not received widespread popularity in the general health care community until the past 15-20 years.

Recently, the interest in spinal manipulation by health care professionals other than chiropractors has increased dramatically. Several factors have changed the attitude among health care professionals regarding spinal manipulation:

First of all, there has been a growing body of research supporting the efficacy of spinal manipulation for a variety of painful disorders related to the spine such as back pain, neck pain and headaches. Spinal manipulation has gone from an unstudied treatment only 25 years ago to perhaps the most thoroughly examined treatment for back pain. Scott Haldeman who is a chiropractor and neurologist at the University of California, and a past president of the North American Spine Society, commented that there are over 50 published research trials that have examined spinal manipulation. No other treatment method in modern medicine has been subjected to such research scrutiny.

The second reason for the change in attitude regarding spinal manipulation is the growing realization in scientific medicine that many standard forms of treatments for spinal conditions are relatively ineffective. Recent studies, such as one conducted by the US Government's Agency for Health Care Policy and Research, have made recommendations against many usual but unproven treatments, including many prescription drugs, various physical modalities such as traction, TENS units, biofeedback, trigger point and epidural injections and needle acupuncture.

The final reason for the change in attitude regarding spinal manipulation is that complementary and alternative approaches to health and medicine are among the fastest growing aspects of health care in the United States. In 1990, one-third of the United States population utilized some form of complementary and alternative treatment. By 2010, it is estimated that over two-thirds of our population will be visiting practitioners of alternative and complementary health care. Chiropractic is the largest group of complementary and alternative health care providers, serving roughly 27 million Americans (10%) each year. Currently there are 55,000 practicing chiropractors, and this is expected to grow to 103,000 by the year 2010.

As with any area of science that expands rapidly, the increasing use of spinal manipulation has created some problems that require society to examine and develop solutions for these previously unseen concerns. Perhaps the most significant concern associated with the growing interest in spinal manipulation is the training and qualifications of those health care providers who are entering this area of treatment and the associated public safety issues. As with any health care procedure, spinal manipulation has its effectiveness and its relative safety strongly influenced by provider skill, which are a result of the providers training.

The issue of safety and spinal manipulation has been examined critically in the past 5-10 years. Few medical scientists question the safety of spinal manipulation of the lumbar spine or low back. Looking at the combined benefit-to-risk profile of spinal manipulation, studies suggest that it has one of the best benefit-to-risk ratios of all treatments administered to patients with spinal disorders. The record, however, appears to be significantly different based on the training and qualifications of the provider performing spinal manipulation.

Describing the factors involved, and the force introduced into the spine during spinal manipulation, Dr. Jay Triano suggests that proper spinal manipulation involves a complex knowledge of the technique, combined with considerable skill. His testing of the biomechanical qualities of a spinal manipulation procedure has shown differences in the parameters of manipulation by as much as 70% between expert and novice practitioners. This suggests a strong correlation between the quality of the spinal manipulation and the practitioners training and experience.

These examples suggest that while spinal manipulation is a very safe alternative for patients with spinal disorders, it is only safe when performed by a practitioner with extensive training in spinal manipulation, and by a provider who performs spinal manipulation frequently enough to maintain proficiency. The contrast between the safety statistics of chiropractors versus other providers strongly suggests that the chiropractic training standards for spinal manipulation should be the standard for all practitioners providing this service.

Many chiropractic physicians have established professional working relationships with physical therapists, massage therapists and other alternative health care providers. We respect there training and expertise in their chosen professions, and feel that they offer a wonderful service to the patients they treat. Periodically, we hear from our patients that a massage therapist tried to "crack their neck", or a student-athlete will state that their coach or athletic trainer tried to "pop their back". Most of these patients are upset and confused by these experiences.

So you see there is a definite need for establishing standards of training and education of individuals who perform spinal manipulation. It is for these reasons that I encourage you to support Senate Bill #2349.

Opening

Good Morning

My name is Jerry Blanchard. I am a Chiropractic physician from Grafton practicing my profession in North Dakota for 35 years. The last 16 years of those I have been involved with the regulatory process serving on the State Board of Chiropractic Examiners for ten years and for the past six years being that boards Executive Director. I also am a director and treasurer of the National Board of Chiropractic Examiners. The NBCE tests all Chiropractic college graduates on their basic science, clinical science, and practical skills including the skills of manual manipulation prior to state licensure.

Thank you for the opportunity to testify today and I will ask for your support of Senate bill 2349.

Manipulation/ Mobilization

Currently there is some confusion regarding the terms spinal manipulation as performed by licensed Chiropractic physicians and joint mobilization as performed by other health care providers. They are not the same.

Spinal manipulation is a physician preferred procedure, as defined by Medicare, in which a highly skilled specific thrust is applied to a spinal segment that moves that joint beyond the normal passive range of motion, but not exceeding the limits of normal anatomical integrity. It is often accompanied by an audible release. Because of the thrust and its speed the patient does not maintain control. This creates potential harm in unskilled hands.

Joint mobilization is a procedure in which the body part is moved up to the limits of the passive range of motion but does not involve a thrust. During mobilization the procedure can be monitored and resisted by the patient who therefore maintains final control thus reducing potential harm.

Clinical trials conclude that results with spinal manipulation as preformed by Chiropractors are superior to join mobilization.

This chart should help explain the three ranges of motion and what is meant by the term the limit of normal anatomical integrity.

Differential Diagnosis

Spinal manipulation also requires that the health care provider performing manipulation has the training and knowledge in differential diagnosis to establish the clinical state of their patient. This is needed in order to determine when it is appropriate to manipulate but more importantly when it is contraindicated to perform spinal manipulation.

Currently three health care professions have portal of entry status and are trained in differential diagnosis including Medical Physicians, Osteopathic Physicians, and Chiropractic Physicians.

Once a differential diagnosis is made by examination and it is concluded that spinal manipulation is appropriate than each individual involved spinal motor unit needs to be examined on every office visit to ascertain how the physician should proceed.

Budget

As a small positive but important feature in these financially stressed times this bill is budget neutral and creates no cost to the state or any health plan.

Safety/ Training

Data by Terrett indicates that 94 percent of spinal manipulation performed in the United States is done by Chiropractic Physicians. The other six percent by other health care providers. The incident rate of reported complications however is that about 30 percent of the complications came form the group performing only six percent of the manipulation. The reason is the training and skill level of the Chiropractic profession. This bills intend is to set the standard for all those performing manipulation.

In the book "The Chiropractic Physician" by David Chapman Smith, attorney and secretary-general of the World Federation of Chiropractic published in 2000, he talked about education and training.

Manual diagnosis and treatment is a complex field requiring extensive full-time education. This exists at the undergraduate or first professional level of Chiropractic and in Osteopathy in Australia and the United Kingdom. It is also found at the postgraduate level for Osteopathy in the Untied States and for physical therapy in Australia and several European countries. Leaders in all relevant professions

including medical specialist with experience in manual medicine agree that weekend and part-time courses are inadequate.

The only government commission that has looked at this issue thoroughly, in New Zealand, concluded that "part time or vacation courses for health professionals should not be encouraged" and that medical doctors would require twelve-months full-time training "to acquire a degree of diagnostic and manual skills sufficient to match Chiropractic standards." Physical therapist would require longer that that.

Closing

During my 16 years of regulatory involvement I have had the privilege of attending numerous national meetings involving the Chiropractic regulatory boards from all 50 states and some foreign lands.

I have learned that very few new ideas in the health industry originate in North Dakota, good or bad.

At these meetings I have constantly heard about the health care trends that are starting in California, Texas, Florida, New York and other states that ultimately show up in North Dakota.

I can tell you that other health care professionals in many states have been seeking the legal right to perform spinal manipulation on their patients without adequate training. I can tell you that I have heard numerous round table conversations from those states about patient complaints regarding injuries that occurred when non-trained health care providers have performed manipulation. I know this is also occurring in North Dakota.

Other states have already passed laws similar to Senate bill 2349 without one negative vote.

In closing, let me state that Senate bill 2349 is not designed to limit any health care provider from practicing spinal manipulation but rather it is designed to insure that all manipulators are properly trained and qualified to perform spinal manipulation efficiently and safely.

I firmly believe it is time for North Dakota to be proactive and to provide the citizens of this great state the assurance that all health care providers in North Dakota performing spinal manipulation are, by law, qualified with the proper license, training and skills to be safe and effective.

Thank you for listening.

TESTIMONY

BY
CALVIN N. ROLFSON
ON BEHALF OF
NORTH DAKOTA CHIROPRACTIC ASSOCIATION
IN FAVOR OF
SENATE BILL 2349

My name is Cal Rolfson, I am an attorney from Bismarck. I am the legislative counsel for North Dakota Chiropractic Association. I appear here in support of Senate Bill 2349.

My purpose will be to review with you the specifics and history of the Bill, followed by some general comments regarding the procedure of spinal manipulation. Following my testimony, doctors of chiropractic licensed in North Dakota will expand on this issue for you, since that is directly within their expertise.

North Dakota is not the first state to have considered legislation similar to Senate Bill 2349. Other states include Tennessee, Virginia, North Carolina, West Virginia, and others. What prompted states to propose legislation of this nature was the desire by some allied health professionals, including some physical therapists without advanced training and education, to do spinal manipulation, believing it is within the scope of their practices.

This issue prompted the North Dakota Chiropractic Association to bring this to the attention of law makers in North Dakota to help reduce any potential adverse impact to the citizens of North Dakota because of untrained persons doing spinal manipulation. I will explain a bit more about that after reviewing the Bill.

An interesting thing happened in the Senate. There was no opposition to the original Bill at the Senate Hearing. The Bill in its original form simply stated that if anyone was going to perform spinal manipulation, the standard would be 400 hours of classroom instruction and 800 hours in supervised clinical training in order to do that procedure.

Several days after the hearing was closed, representatives of the North Dakota P.T. Association appeared in the Senate Human Services committee with their lobbyist, Jack McDonald, who is also the Special Assistant Attorney General for the Board of Physical Therapy to oppose the Bill and offer an amendment. The Senate committee, I suppose wanting to be fair to the PT Association, allowed them to come back to the Committee and present lengthy testimony. I was not notified of this rehearing.

Several days before, Mr. McDonald and I had met to try to reach a compromise on the Bill. We did not reach an agreement.

The original Bill was changed in Committee by adopting Mr. McDonald's

amendments which resulted in the Engrossed Bill before you. The Bill now has the 400 hours and 800 hours criteria only apply to chiropractors.

Originally the NDCA was opposed to those changes, which were made over their objection to please physical therapists, whose legal definition of their craft doesn't even mention spinal manipulation as a permissive. In my research, I can't locate an administrative rule or a PT Board position that permits PTs to do spinal manipulation, nor can I locate any policy standard of practice by the PT Board stating that PTs may do spinal manipulation.

However, the NDCA now believes that Engrossed Senate Bill No. 2349 should pass as a standard for spinal manipulation for chiropractors. Safety of the public should require nothing less. Therefore, the NDCA urges this committee to give a "DO PASS" to Engrossed Senate Bill 2349.

This Bill in it original form did not restrict anyone from practicing spinal manipulation or spinal adjustment who would have the requisite training. It was intended as a pro-active approach to help protect our citizens from the trends seen in other states where some untrained health professionals engage in spinal adjustment and place their patients at potentially serious risk of harm.

Lines 1 through 12 of the original Bill, stated that no person (whether chiropractor, physical therapist, massage therapist or anyone else) may perform a

spinal manipulation or spinal adjustment without:

1. The ability to differentially diagnose the need for such a procedure;
2. Receiving a minium of 400 hours of classroom instruction in spinal manipulation or spinal adjustment;
3. Practicing a minium of 800 hours in supervised clinical training at facilities where such diagnosing and spinal manipulation procedures are the primary method of treatment.

In the Bill's amended form, the differential diagnosis, classroom and clinical training now apply only to chiropractors.

Lines 12 through 15 of the Bill essentially define spinal manipulation and spinal adjustment as interchangeable terms that identify the skillful and beneficial treatment where the practitioner uses direct thrust as a technique to move a patient's joint beyond its normal range and is done without exceeding the joint's limits of anatomical integrity.

It is important to understand what spinal manipulation entails. Attached to my testimony is a graphic that helps explain spinal manipulation. Please refer to that. Although mobilization and manipulation sounds similar, there is a difference in the two procedures and the expertise required to preform them.

Referring to the attached illustration, the area on each side of vertical

represents the range of movement a patient can make without assistance. This is the active range of motion. (If you will take your index finger, hold it up and try to move it back as far as you can on your own, that is the active range of motion of your finger.) The passive range of motion is the range of movement that can be accomplished with assistance and is represented by the next area. That is the mobilization area. Mobilization into this passive range occurs when you push your extended index finger as far back as it can go.

"Manipulation" occurs when the joint is carried beyond the normal passive range of movement without exceeding the boundaries of anatomical integrity. The movement is accomplished to the spine with a brief sudden and carefully administered dynamic thrust that is often (though not always) accompanying by an audible sound. Manipulation is represented by the most outside areas in the illustration. Beyond manipulation is the dangerous portion that may subject a patient to injury. Great skill and training is required to take the joint into its narrow target range where the therapeutic benefits of manipulation occur and without moving past that point to the point of injury. This is the art and science practiced by doctors of chiropractic for over a century.

The one question that I anticipate may be asked is why 400 hours of academic training. In a survey of chiropractic colleges to determine the number

hours in which spinal manipulation education and training is taught, the number of education hours for chiropractors to do spinal manipulation ranged between 885 hours and 330 hours. 400 hours was selected as one of the lowest hours of training in such schools and is the standard set in the law of those states that now have such a law on their books.

On behalf of the NDCA, I urge your favorable consideration of a "do pass" to Engrossed Senate Bill 2349.

Calvin N. Rolfson
Legislative Counsel
North Dakota Chiropractic Association
(Lobbyist No. 144)

SB 2349

Testimony on Behalf of Physical Therapist

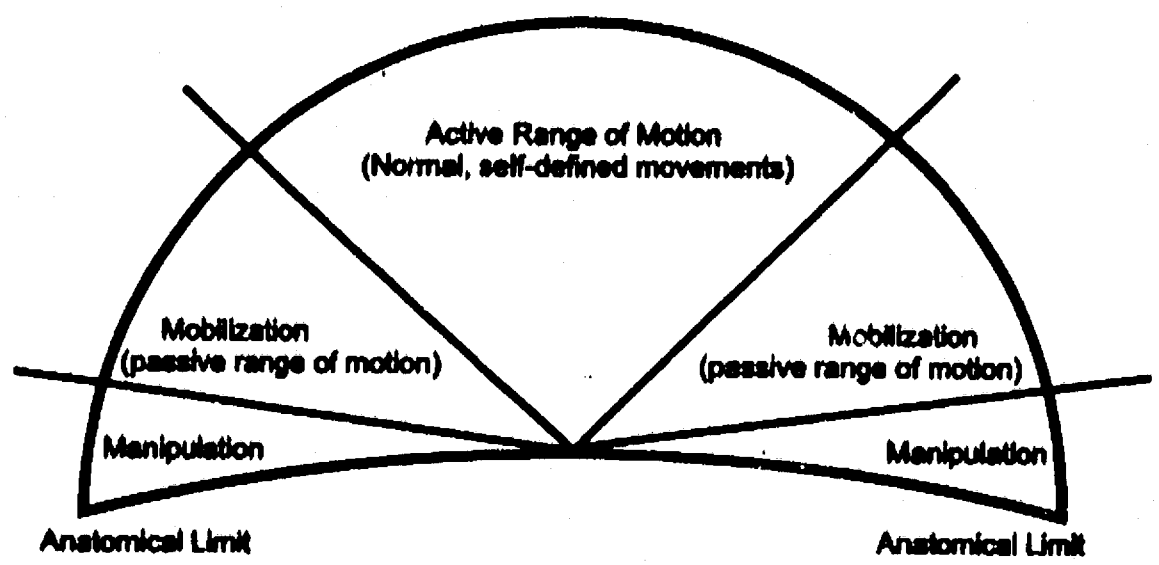
- Education of PT's is extremely well regulated so most programs look somewhat alike.
- The job of the PT education program is to graduate entry-level generalists. Specialization occurs after a student becomes a licensed PT. Students are taught that lifelong learning is a professional obligation.
- Professional education for physical therapists includes 3 full academic years and 2 full summers, which occur *after* at least 3 years of pre-requisites. The breadth and depth of this curricula is much more comprehensive than the written testimony provided by the chiropractors that was included with the introduction of this bill in the Senate. For example, it has been reported that we do not teach orthopedics. Our students have 128 hours of Kinesiology; 96 hours of basic evaluation of the musculoskeletal system; and 128 hours of advanced orthopedics (all in the realm of orthopedics). This is only the didactic portion of the curriculum. Students also spend hundreds of hours in the clinic practicing their skills under the tutelage of an experienced physical therapist.
- The courses just cited build the foundation for our students to know the anatomy and mechanics of every joint in the body-including the joints of the spine. They practice feeling normal joint movement-how the joint surfaces move within the joint capsule and how the joint moves overall. This helps them identify joint restrictions when they are working in the clinic.
- It was also reported we do not teach diagnosis. The Guide to Physical Therapy practice is the current "Physician's Desk Reference" for physical therapy, which is used throughout the curriculum. The Guide is based on physical therapy diagnosis and treatment-which includes examination, evaluation, establishing a diagnosis, prognosis, and an intervention in all areas of the body-specifically musculoskeletal, cardiovascular, integumentary, and neuromuscular. Thus, in all PT curricula, diagnosis is stressed throughout the curriculum. When combined with a course in pathophysiology, this amounts to hundreds of hours of teaching diagnosis. The testimony provided by chiropractors was poorly researched as all physical therapy schools in the United States are required to teach these areas plus more.
- We have several specializations and certifications. Manual therapy is one of them. Physical therapists develop the foundation for manual therapy through many hours of education in physical therapy professional education programs. Specialization occurs through continuing education programs.
- Continuing education programs in manual therapy are NOT just one weekend. They cover either a year at a residency program or several weekends.
- Professional physical therapy schools teach the skills necessary in all areas of practice for our graduates to be safe and effective. Physical therapists in this state have a great record of safety and monitoring themselves through the State Board of Medical Examiners. With this record, an amendment that allows chiropractors to monitor physical therapists education is not necessary nor within their rights.

I have enclosed the University of Mary Proposed DPT curriculum-which is very similar to the MPT curriculum only more spread out. Note that it includes several orthopedics courses which specifically teach mobilization/manipulation.

Jodi Roller, PT, Ed.D. Program Director

University of Mary

Manipulation Defined



Active Range of Motion:
This is the range through which a person can voluntarily move a joint
Example: extend your index finger back as far as it will go under it's own power.

Mobilization:
This occurs within the limits of the passive range of motion.
Extending into this range past the active range requires the application of an outside force.
Example: bend your index back a bit farther with the opposite hand until you meet resistance.

Manipulation:
This involves moving the joint beyond the limits of passive range of motion but not past the limits of anatmoical integrity.
Extending into this range requires the application of a quick thrust.
To do this without going beyond the anatomical limits and causing injury requires a high level of training and skill.

Testimony

By

Jeffrey J. Askew, D.C.

In support of Senate Bill 2349

My name is Jeff Askew and I'm a Doctor of Chiropractic. I've been practicing in Bismarck for the past 23 years. I am here in support of Senate Bill 2349. I believe manipulation by untrained people is an unwise and unsafe practice and this bill can benefit the people of North Dakota.

I would first ask that, throughout the testimony from all sides today, the committee will keep in mind that our only concern is regarding manipulation, as defined by Mr. Rolfson, using a dynamic thrust to take a joint into the parpahysiological space. We have no interest in addressing mobilization or the many soft tissue techniques that PT's may refer to in a more general sense in conversation as being "manipulation."

I have a deep respect for the skills and thought processes and integrity of my health professional colleagues in the field of physical therapy. I have an excellent ongoing working relationship with many of them. I have many patients who are PT's. Many of my best friends are PT's. I was frankly surprised by the uprising we caused among our PT friends when we introduced this bill. Since I don't believe there are more than a very small handful of PT's in the state performing infrequent manipulation, I didn't anticipate that so many PT's would find these training standards so objectionable.

Chiropractic was invented 108 years ago in 1895 and, like medicine at that time, was very primitive by today's standards. Since then, the science and art of chiropractic has been tested, studied, practiced, tweaked, honed, and perfected for a century until it has reached it's current status. It enjoys a current wave of support from scientific data demonstrating that spinal manipulation is often the most effective and cost-effective treatment for a number of musculoskeletal conditions, including lower back pain, neck pain, and headaches. Science has shown us that many therapeutic effects take place after spinal manipulation that **do not** occur with mobilization, or only occur to a much lesser degree. These are complex physiological responses that we don't need to go into here, but they include reduction of pain transmission, reflexive relaxation of deeper spinal muscles, mechanical release of trapped connective tissues, breaking of joint adhesions, increased blood circulation, and release of trapped spinal nerves.

Chiropractic has gone from primitive to refined, from being labeled as quackery to mainstream, from being rebuked to being envied and mimicked.

This wave of success and current state of high public demand has resulted in a surge in interest in spinal manipulation, even from those who have mocked us for a century. Well-intentioned but untrained people have begun to dabble with spinal manipulation, with an inadequate understanding of the difficulty of performing spinal manipulation effectively and safely. This has led to an increase in concern about the level of training of practitioners of spinal manipulation.

Chiropractic has built an excellent and enviable track record of safety for spinal manipulation. Even though manipulation has one of the highest benefit to risk ratios of all treatments for spinal disorders, there is a potential for adverse reactions. These negative side effects range from the infrequent minor sprains and strains, to the extremely rare but potentially fatal stroke. In testimony before the Senate Committee earlier, someone tried to make the case that patient's were not really at higher risk when manipulated by a PT than when manipulated by a Doctor of Chiropractic because they had a study that showed many more injuries after chiropractic adjustments than after PT manipulations. When we get past the mathematical smoke and mirrors and look at the fact that almost all spinal manipulation in the United States is performed by Doctors of Chiropractic, we can see from other studies that **the risk of adverse reaction to spinal manipulation is up to six times higher when performed by those without comprehensive training.**

It has also been said in testimony regarding this bill that chiropractors don't own spinal manipulation. I'm not here to claim to own manipulation. What I can say, however, is that …

- Doctors of Chiropractic perform 96% of all of the spinal manipulation in the U.S.,
- We have been doing it for 108 years,
- We have the most training and the most experience,
- The very substance of our day revolves around spinal manipulation,
- We are arguably in the best position to assess what it takes to be effective and safe.

That is why we are in favor of setting these standards, *even if*, for now, the standards only apply to us.

The argument has been made that no one has died yet in North Dakota as a result of spinal manipulation by a PT, therefore there is no need for a law to protect the public. North Dakota has a small population. Any uncommon occurrence is going to be *rare* here, but **that doesn't change the statistical risk** to a given individual when manipulated by an under-trained practitioner. And it doesn't mean our people don't deserve protection.

Here's what the world's leading medical doctors in the field of manual medicine have to say about the difficulty of becoming adequately adept at spinal manipulation[1]:

1) William Kirkaldy-Willis, MD, orthopedic surgeon, researcher, Professor Emeritus at the Department of Orthopedic Surgery at the University of Saskatchewan College of Medicine, and editor of the textbook *Managing Low-Back Pain*, advises:

> **"Spinal manipulation requires full-time practice and family physicians should refer to a chiropractor or other specialist."**

2) Alan Stoddard, DO, MD, of England, qualified in spinal manipulation both as an osteopath and a specialist in physical medicine, says:

"The art of manipulation depends on the ability of the practitioner to combine the forces he uses such that the maximum leverage occurs precisely at the level of the restricted joint. Such skill takes a great deal of practice to perfect. Clearly those engaged in continuous practice are likely to be more skilled than those who manipulate only on rare occasions. The concert pianist practices his art daily to maintain a high standard. This applies equally to the art of manipulation."

3) James Cyriax, MD, a renowned author in orthopedic medicine from England, says:

"To learn when to manipulate and when not, and what sort of maneuvers to use, is a diagnostic problem involving years of study...(it) requires a high degree of knowledge and skill."

4) Robert Maigne, MD, a renowned author on physical medicine from France:

"Prolonged training under guidance is indispensable."

5) ...And, finally, Karel Lewit, MD, internationally known neurologist with the Czech School of Manual Medicine:

"The great majority of (medical) students and doctors who learn manipulation are taught far too little about how, where, and when to use it...they are clinically blindfolded.

The practice of spinal manipulation and understanding all the many forms of disturbed function of the motor system requires great skill demanding long training."

The knowledge skill and artistry that is involved in spinal manipulation is not always appreciated by the untrained. In addition to mastering tension presets, lines of drive, torques, depth of thrust and speed of thrust, the practitioner must have the diagnostic skills to determine if spinal manipulation is the appropriate course of treatment, what type of manipulation to perform to maximize the benefit to risk ratio, whether or not to discontinue or alter the course of manipulative treatment, and when to conduct further diagnostics tests or make a referral to another type of provider. At the onset, it is necessary to determine whether the patient's complaint is due to a mechanical joint problem or a tumor. Without training in differential diagnosis, this would not be possible.

We are not anti-PT. We welcome competition from other providers and publicly support the right of other providers to acquire our skills and perform our services. We just feel a practitioner should have adequate training before they take another person's neck past the limits of passive range of motion with a dynamic thrust.

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[1] *The Chiropractic Profession*, David Chapman-Smith

March 12, 2003

HOUSE HUMAN SERVICES COMMITTEE
SB 2349

REPRESENTATIVE PRICE AND COMMITTEE MEMBERS:

My name is Jack McDonald. I'm appearing here today on behalf of the North Dakota Physical Therapy Association and the North Dakota State Examining Committee for Physical Therapists. We oppose any efforts to impose unneeded and unnecessary regulations on physical therapists and ask that you either pass Engrossed SB 2349 **without amendments** or, in the alternative, just **kill the bill.**

In North Dakota, there are some 25 – 30 licensed professionals in various occupations and professions, ranging alphabetically from abstracters to wholesale drug distributors. In each instance, state law authorizes the various licensing boards to protect the public safety by assuring that the practioners the boards license are competent and fully trained to practice their profession. However, with this bill, the chiropractors say they don't believe in this system, and that they are the only persons with the "legal authority" (see line 8 of the engrossed bill) to determine who can practice certain health care procedures.

In their testimony, the chiropractors cite alleged adverse results to patients from spinal manipulation treatments by physical therapists, but list no references to support these claims. On the other hand, a comprehensive 1999 study on this very issue by the Virginia Board of Medicine (see **Tab** 2) showed that in one limited study 50 of the 78 manipulation cases involving death or disability were caused by chiropractors, and that of the three attributed to physical therapists, two were in foreign countries.

The Virginia study also showed (**Tab** 4) that for the 1991 – 1998 period, there were 537 complaints filed against chiropractors and 112 complaints filed against physical therapists, and that no case had ever been documented in Virginia against a physical therapist performing spinal manipulation or mobilization.

The National Federation of State Boards of Physical Therapy reports that in its data base compiled since 1996 there has never been a final order concerning a physical therapist using manipulation as a therapeutic modality (**Tab** 7) while CNA, the

company that nationally provides the majority of malpractice insurance for physical therapists, says there are no trends that indicate this is a risk factor (Tab 8).

There has never been a complaint filed in North Dakota against a physical therapist involving spinal manipulation.

The chiropractors in their testimony say that manipulation is not included in the physical therapists' scope of practice and that they do not have adequate training in diagnosis and manipulation. Again, this is simply not true. As the Virginia study noted (Tab 1), manipulation has been an integral part of physical therapy practice since 1928. It cites a New York study to show that what physical therapists refer to as "Stage V Mobilization" is synonymous with what chiropractors refer to as "manipulation" (Tab 3). Chiropractors do not own the term "manipulation." It's used in many other professions. In 2000, the Supreme Court of Canada rejected a lawsuit by chiropractors and said physiotherapists could practice mobilization and manipulation (Tab 11).

You have heard from others about the educational background of physical therapists. Note the course descriptions for the University of North Dakota (Tab 10) that show 3,360 professional contact hours and similar offerings by the University of Mary (Tab 9). Note the many, many hours of clinical work and classroom work involving diagnosis, mobilization and manipulation.

Now compare these course offerings with the alleged comparisons shown by the chiropractors where the physical therapists have no training in chemistry, microbiology, diagnosis, x-ray and just minimal training in many other fields. These amazing statistics show chiropractors have two to three to four times as much training in most medical fields such as diagnosis, orthopedics, anatomy and physiology as physicians.

The Virginia study also cites a 1999 State of New York finding (Tab 6) that spinal mobilization or manipulation is an integral part of the practice of physical therapy.

You have also heard from physical therapists about the additional training they receive in order to do more specific manipulation. Because of a their training in mobilization and manipulation, and their other skills and extensive training in anatomy, physiology, examination and evaluation skills, as well as their pathology and differential diagnosis backgrounds, they can learn some of the manipulation techniques in weekend

courses. At Tab 12 is a report on general physicians without prior training in manual therapy successfully learning manual therapy techniques in two-day workshops.

If the chiropractors believe physical therapists and others are practicing beyond their scope of practice, then they should file complaints with the appropriate licensing boards or with the courts, rather than try to regulate these other professions.

We believe, therefore, that you should find, as did the Virginia Board of Medicine after its comprehensive study, at Tab 5, that there is no evidence to suggest this legislation is necessary for public safety, and further that it is both unnecessary and unwarranted, and that there should be no limitations placed on the professions that currently utilize manual spinal care or spinal manipulation within their scope of practice.

THANK YOU FOR YOUR TIME AND CONSIDERATION.

VIRGINIA BOARD OF MEDICINE
DEPARTMENT OF HEALTH PROFESSIONS

Study of Spinal Manipulation Pursuant to Request from the Chair of the Senate Committee on Education and Health

Background and Authority:

During the 1999 Session of the General Assembly, the Senate Committee on Education and Health considered Senate Bill 1141, relating to manual spinal care or spinal manipulation. The Committee failed to report the bill but, at the request of the patron, Senator Edward Schrock, asked the Virginia Board of Medicine to examine the issues relating to spinal manipulation. A letter conveying that request was sent by the Chair of the Committee, Senator Jane Woods, and received by the Board on April 27, 1999 (A copy of the letter from Senator Woods is attached to this report.)

Senate Bill 1141 defined "manual spinal care" as a skill procedure whereby a person uses a directed thrust, contact or leverage to the articular joints with the intent of affecting the structure and/or function of a person's spine. According to the legislation, the procedure includes, but is not limited to, uniquely distinct procedures, such as osteopathic manipulative treatments, spinal manipulations, and chiropractic adjusting techniques and should "only be performed by persons who are (i) doctors of osteopathy, chiropractic or medicine, licensed in Virginia and (ii) practitioners of the specific form of care rendered." Opposition to the bill arose because of its restrictions on the current scope of practice for physical therapists, who are allowed to perform manipulation or mobilization on a patient under the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry or dental surgery. The Board of Medicine did not take a position on this or any other piece of legislation during the 1999 Session.

A similar bill was introduced in the 1998 General Assembly, carried over to the 1999 Session, and not reported by the Senate Committee on Education and Health. Senate Bill 600 defined "spinal manipulation" as the skillful treatment of the joints of the spine through the use of directed thrust or leverage to move or mobilize a joint in the patient's spine which is performed by a licensed practitioner of chiropractic or osteopathic medicine; it does not include orthopedic or medical reduction of fractures or dislocations. The legislation further provided that 200 hours of training in a course or institution approved by the Board is required for a licensed physician, osteopath, or chiropractor to be able to perform spinal manipulation. At its meeting on February 5, 1998, the Board voted to oppose any prohibition preventing an individual or group of individuals from doing manipulation.

Study Task Force of the Virginia Board of Medicine

For the purpose of reviewing information on spinal manipulation and data on the risk of harm to the public, receiving public comment, and bringing recommendations to the Board, the President of the Board of Medicine appointed a Study Task Force. With James F. Allen, a medical doctor specializing in neurosurgery and member of the Board serving as Chairman, the Task Force consisted of Paul M. Spector, an osteopathic member of the Board, Jerry R. Willis, a chiropractic member of the Board, and Winston R. Pearson, Jr., Chairman of the Advisory Board on Physical Therapy,

The Executive Director of the Board of Medicine, Warren K. Koontz, M.D. and the Regulatory Boards Administrator for the Department of Health Professions, Elaine J. Yeatts, provided staff assistance for the Committee. In addition, Kirsten A. Barrett, a policy research analyst with the Department conducted much of the basic research and prepared a draft report on the practice and risk of manipulation.

Definitions and Description of Spinal Manipulation or Manual Spinal Care

At its initial meeting, the study task force was asked to define spinal manipulation or manual spinal care, terminology referenced in Senator Woods' letter. Dorland's Medical Dictionary defines manipulation as "skillful or dexterous treatment, as by hand. In physical therapy, the forceful passive movement of a joint beyond its active limit of motion." There is no definition of "spinal manipulation" in the dictionary nor was there agreement among chiropractors and other practitioners about the definition and description of manual spinal care and related terms. Seeking clarification, the Executive Director of the Board of Medicine requested information and definitions from state boards and associations relating to the professions of medicine, osteopathy, podiatry, chiropractic and physical therapy.

Definitions provided by the Virginia Chiropractic Association are as follows:

> **Spinal Manipulation:** Passive movement of short amplitude and high-velocity which moves the joint into the paraphysiologic range. This is accompanied by cavitation or gapping of the joint that results in an intrasynovial vacuum phenomenon thought to involve gas separating from fluid.
>
> **Spinal Mobilization:** Passive movements within physiological joint range of motion without cavitation or the popping sound inherent to manipulation.

Definitions provided by the Virginia Physical Therapy Association and the American Physical Therapy Association are as follows:

> **Manual Therapy:** A broad group of skilled hand movements, including but not limited to mobilization and manipulation, used by the physical therapist to mobilize or manipulate soft tissues and joints for the purpose of modulating pain; increasing range of motion; reducing

or eliminating soft tissue swelling, inflammation or restriction; inducing relaxation; improving contractile or non-contractile tissue extensibility; and improving pulmonary function. Manual therapy techniques include connective tissue massage, joint mobilization and manipulation, manual lymphatic drainage, manual traction, passive range of motion, soft tissue mobilization and manipulation, and therapeutic massage

Spinal Care: A generic term that describes no specific intervention, philosophy or methodology. In contrast, the Guide to Physical Therapist Practice describes the "disablement model" and defines "impairment," "functional limitation," and "disability." These are terms that can be applied to any human condition including those that involve the spine.

Mobilization: A skilled passive hand movement that can be performed with variable amplitudes at variable speeds.

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

When applied to treatment of spine dysfunction, manual therapy techniques are often termed manual spinal care or manual spinal therapy. The term's spinal mobilization or spinal manipulation may be used depending on the intervention performed.

Utilization of Manual Therapy Techniques in Physical Therapy:

Historically, physical therapists have utilized manipulation in their practices; the literature supporting its use by physical therapists dates back to 1928. Manual therapy techniques, including mobilization and manipulation, are identified as direct physical therapy interventions in the Guide to Physical Therapist Practice, Revised 4/99. In the Guide, intervention is defined as "the purposeful and skilled interaction of the physical therapist with the patient/client – and, when appropriate, with other individuals involved in care – using various methods and techniques to produce change in the condition that are consistent with evaluation, diagnosis and prognosis. Decisions are contingent on the timely monitoring of response to intervention and the progress made toward anticipated goals and expected outcomes."

Manual therapy techniques may be an appropriate intervention for patients with musculoskeletal, neuromuscular, cardiopulmonary and/or integumentary dysfunction. Candidates for manual therapy include patients / clients with: limited range of motion (ROM), muscle spasm, pain, scar tissue or contracted tissue and/or soft tissue swelling, inflammation or restriction. The anticipated goals to be achieved after the application of manual therapy techniques may include any or all of the following:

1. Increased ability to perform movement tasks
2. Decreased edema, lymphedema or effusion
3. Improved integumentary integrity
4. Improved joint integrity and mobility
5. Improved motor function

6. Reduction in muscle spasm
7. Reduction in pain
8. Improvement in quality and quantity of movement between and across body segments
9. Reduction in risk of secondary impairment
10. Reduction in soft tissue swelling, inflammation or restriction
11. Increased tolerance to positions and activities
12. Decreased utilization and cost of health care services
13. Improved ventilation, respiration and circulation

Utilization of Manipulation in Osteopathic Medicine:

According to the American Association of Colleges of Osteopathic Medicine, Osteopathic Manipulative Treatment (OMT) is a system of manual manipulation treatment developed by Dr. Andrew Taylor Still in the late 1800's, based on his recognition of the role that the musculoskeletal system plays in the body's continuous effort to resist and overcome illness and disease. OMT is composed of a spectrum of manual techniques that physicians may use to alleviate pain, restore freedom of motion, and enhance the body's own healing power. Often these techniques are used in conjunction with more conventional forms of medical care, such as prescribing medication or performing surgery. The most commonly used manipulative techniques in osteopathy are: articulatory techniques, counterstrain, cranial treatment, myrfascial release treatment, lympathic techniques, soft tissue techniques, and thrust techniques.

Education and Training

Physical Therapy Education

There are presently 189 accredited and 25 developing physical therapy programs in the United States (APTA, 1999). Of the accredited programs, 24 are at the bachelor's level, 158 at the master's level and 7 at the doctoral level. In Virginia, there are four accredited physical therapy programs and one developing physical therapy program. By 2002, all physical therapy education programs will be at the Master's level or higher.

Program accreditation is granted through the Commission on Accreditation of Physical Therapy Education (CAPTE). CAPTE is the only recognized agency in the United States for the accreditation of physical therapy and physical therapist assistant programs. Although accreditation is a voluntary process, graduation from an accredited physical therapy education program is one of the necessary requirements for licensure. Since licensure is necessary in all fifty states at this time, institutions necessarily seek accreditation through CAPTE. In addition, many states, including Virginia, require the applicant to successfully pass the national physical therapy examination which has been jointly developed, and is jointly administered and scored, by the Federation of State Boards of Physical Therapy and the Professional Examination Service (PES).

In the accreditation process, CAPTE uses the Evaluative Criteria for the Accreditation of Education Programs for the Preparation of Physical Therapists. The Evaluation Criteria outlines four areas of

compliance for institutions. These are organization, resources and services, curriculum development and content and program assessment.

Entry-level skills and knowledge necessary for safe physical therapy practice are outlined in the section of the Evaluative Criteria addressing curriculum development and content. Topic areas include, but are not limited to, communication, critical inquiry and decision-making, professional development, examination, plan of care, intervention, prevention and wellness and social responsibility. Manual therapy techniques can be found in the intervention section (3.8.3.28f). The framework provided in the curriculum development and content section of the Evaluative Criteria is expanded on in the Normative Model of Physical Therapist Education.

The Normative Model of Physical Therapists Professional Education includes manipulation as course content and skill acquisition components. The Normative Model is used by educational programs to determine necessary course content for the physical therapy curriculum and details the educational outcomes for the graduate to achieve in many areas, including intervention. Included in the section on intervention are educational outcomes related to safe practice and skill acquisition. The following is a listing of the educational outcomes related to safe practice:

13.1 Practice in a safe setting and manner to minimize risk to the patient, client, therapist, and others.

The graduate:

- is aware of high-risk aspects of practice.
- is aware of measures to prevent risk.
- corrects unsafe conditions.
- applies standard safety procedures.
- seeks assistance when necessary.
- instructs others in safety procedures
- documents critical incidents
- is aware of impaired-provider issues.
- implements risk-management procedures after a critical incident.

In regards to skill acquisition in performing various physical therapy interventions, the following educational outcomes are identified in the Normative Model:

13.2.1 Provide direct physical therapy interventions to achieve goals that facilitate expected patient or client outcomes based on the examination and on the impairment, functional limitations, and disability.

The graduate:

- administers physical therapy intervention to achieve the desired patient or client response
- delivers treatment procedures accurately based on applicable practice guidelines.

- performs treatment procedures with consideration for safety, timeliness, energy conservation, and organization, including preparation, sequencing, progression, and setting priorities.
- modified intervention based on the attainment of outcomes based on impairment, functional limitations, and disability.
- confers with patient concerning outcomes.

Manual therapy is listed as an intervention in the Evaluative Model and its components are described in the Normative Model. Manual therapy may include connective tissue massage, joint mobilization and manipulation, manual lymphatic drainage, manual traction, passive range of motion, soft-tissue mobilization and manipulation and therapeutic massage.

Additionally, in the area of examination, the Normative Model details the nature of joint integrity and mobility testing. This is germane to the issue of manual therapy. Joint integrity and mobility tests may include:

- Analysis of the nature and quality of movement of the joint or body part during the performance of specific movement tasks
- Assessment of joint hypermobility and hypomobility
- Assessment of pain and soreness
- Assessment of response to manual provocation of the joint
- Assessment of sprain
- Measurement of soft tissue restriction

Utilization of the Evaluative Criteria and Normative Model at the Institutional Level

Samples of actual course syllabi from Shenandoah University School of Health Professions, Program in Physical Therapy and from Hampton University demonstrate how the course objectives, the curriculum development and content criteria relate to manual therapy techniques, as set forth in the Evaluative Criteria and Normative Model.

The Department of Physical Therapy at Virginia Commonwealth University provided a list of course work in which the content relates to manipulation, with the number of contact (lecture and lab) hours of training that each student receives.

Content Related to Manipulation	Course Name	Contact Hours
Gross Anatomy	PHT 501	72 hours lecture, 72 hours lab
Histology/Microscopic Anatomy	PHT 505	56 hours lecture, 20 hours lab
Kinesiology	PHT 502	30 hours lecture, 30 hours lab
Biomechanics	PHT 507	30 hours lecture, 30 hours lab
Examination of the patient with Musculoskeletal (including manipulation of the spine)	PHT 508	90 hours lecture, 45 hours lab (appox. half spent on the spine)
Pathology of the musculoskeletal system (manipulation of spine	PHT 540	15 hours lecture

included)		
Pathology of the musculoskeletal system	PHT 548	15 hours lecture
Treatment of patients with musculoskeletal problems	PHT 548	60 hours lecture, 30 hours lab (approx. half spent on spine)
Traction and massage of the spine	PHT 533	5 hours lecture, 10 lab

In addition to course work, there are a number of methods by which physical therapists acquire clinical competence in manipulation. They include:

- Clinical programs in entry level education - Marymount University in Northern Virginia has specialized clinical opportunities available for students wishing to become proficient in manipulation which range from 3 to 6 months in length and provide direct instruction and supervision.
- Post-professional degree programs - Several exists in universities in the United States both at the masters and doctoral level that offer extensive didactic and clinical training in manipulation.
- Post-professional continuing education - There is an array of post-professional continuing education, such as the North American Institute of Orthopedic Manual Therapy (courses range from 42 to 84 hours) offered around the country which are devoted entirely or partially to manipulation. Included in these are MAPS seminars (Maitland Australian Physiotherapy Seminars) at which accurate assessment and clinical decision-making are emphasized and the methodology includes live patient demonstrations and a hands-on laboratory format.
- Post-professional clinical residency programs - A number of programs exist across the country which offer extensive clinical and didactic training in the area of manipulation.
- Orthopedic Certified Specialist Certification - The American Board of Physical Therapy certifies specialists in a number of specialty areas of physical therapy, including one related to manipulation. The minimum eligibility requirements include at least 6,000 hours of direct patient care in orthopaedics or evidence of completion of an accredited clinical residency and passage of a written examination of advance knowledge and clinical skills.
- Clinical mentorships - The American Physical Therapy Association offers a program designed to assist clinicians interested in developing advanced clinical competencies by providing them with mentors who have expertise in the area of manipulation.

Chiropractic Education Programs

There are presently 16 chiropractic colleges accredited by the Commission on the Accreditation of the Council of Chiropractic Education (CCE). The CCE is recognized by the United States Department of Education. As with physical therapy, in order to obtain a license to practice chiropractic in any of the fifty states, graduation from an accredited chiropractic institution or educational program is one of the necessary requirements. In addition, many states, including Virginia, require the applicant for licensure to successfully complete the four-part National Board of Chiropractic Examiners examination (NCBE). This examination covers basic sciences, clinical sciences, clinical competency and practical skills.

The CCE has described the minimal acceptable clinical criteria necessary for the competent practice of chiropractic. These are found in the Standards for Chiropractic Programs and Institutions, Section 3. The Criteria for Accreditation V. Mission Elements – Clinical Competencies. Included are clinical competencies in the areas of history taking, physical examination, psychosocial assessment, diagnosis and clinical impression and adjusting competencies. Attitudes, knowledge and skills are described for each area of clinical competence.

The following is an example of the attitudes, knowledge and skills associated with the adjusting competencies.

Adjusting Competencies:

The adjustment is a precise procedure that uses controlled force, leverage, direction, amplitude, and velocity directed at specific articulations. Doctors of chiropractic employ adjustive procedures to influence joint and neurophysiologic function. Other manual procedures may be used in the care of patients such as manipulation, which are not as precise or specific.

Attitudes:

1. Appreciate the need to explain what will be done when administering the adjustment, discuss risks, and recognize the potential for patient apprehension and concern.
2. Demonstrate awareness of the need to accommodate patient privacy and modesty in the course of administering chiropractic adjustments.
3. Demonstrate awareness of the need to reassess and modify adjustive methods appropriate to the needs of the patient.

Knowledge:

1. Demonstrate an appreciation of the normal and abnormal structural and functional articular relationships.
2. Demonstrate awareness of the pathophysiology and methods of evaluating articular biomechanics.
3. Understand the principles and methods of various adjustive and manipulative procedures common to the practice of chiropractic.
4. Recognize the clinical indications and rationale for selecting a particular adjustive or manipulative procedure.
5. Be able to select and appropriately use equipment and instruments necessary to administer adjustive or manipulative procedures.
6. Recognize the indications and contraindications for, and potential complications of adjustive and manipulative procedures.

Skills:

1. Demonstrate an ability to palpate specific anatomical landmarks associated with spinal segments and other articulations.
2. Select and effectively utilize palpatory and other appropriate methods to identify subluxations of the spine and other articulations.
3. Effectively use equipment and instruments that support adjustive or manipulative procedures.

4. Demonstrate an ability to effectively deliver the correct adjustive or manipulative procedures which utilize appropriate positioning, alignment, contact and execution.
5. Demonstrate the ability to effective administer a variety of adjustive or manipulative procedures in order to accommodate differences in patient body type and clinical status.
6. Accurately record the method of determining location, specific procedure followed and outcome of adjustment.
7. Select and employ palpation and other methods for identifying the effects following adjustive or manipulative procedures.
8. Communicate the health benefits of adjustments to patients.
9. Demonstrate an ability to perform adjustive procedures in a confident and decisive manner.
10. Discuss potential immediate or delayed reactions or responses to the adjustment.

[From: Standards for Chiropractic Programs and Institutions, January 1999; www.cce-usa.org]

All professionals licensed by the Board of Medicine have an obligation to practice with skill and safety. A physician licensed to practice medicine or osteopathic medicine is authorized to practice "the prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method." (§ 54.1-2900 of the *Code of Virginia)* Nothing in law or regulation stipulates that additional training beyond that required for basic licensure must be acquired to perform complex brain surgery or other such specialized practices. The professional is expected to practice within his or her scope of education, training and ability. The same may be said about other licensees of the Board who are all subject to disciplinary provisions in § 54.1-2914 of the *Code of Virginia.*

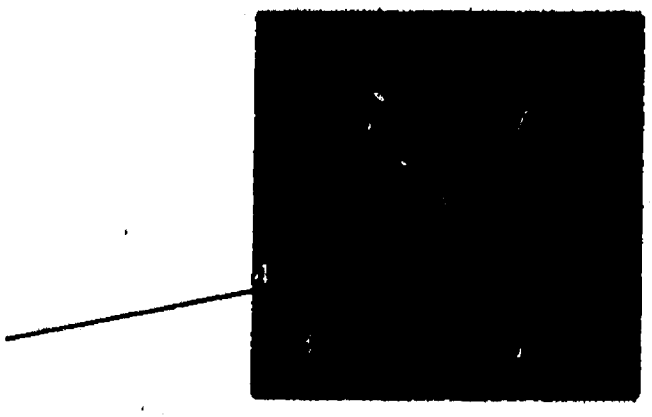
In the section on unprofessional conduct (§ 54.1-2914), the *Code* provides that any practitioner of the healing arts regulated by the Board shall be guilty of unprofessional conduct if he: 1) conducts his practice in a manner contrary to the standards of ethics of his branch of the healing arts; 2) conducts his practice in such a manner as to be a danger to the health and welfare of his patients or to the public; or 3) performs any act likely to deceive, defraud or harm the public. For example, the Guide of Professional Conduct for the American Physical Therapy Association provides that if the examination of a patient reveals findings that are outside the scope of the physical therapist's knowledge, experience or expertise, the physical therapist shall so inform the patient and refer to an appropriate practitioner. If, therefore, a practitioner licensed by the Board, whether it be a physician, an osteopath, a chiropractor or a physical therapist engages in the practice of manipulation without the necessary skills and ability to treat a patient safely and competently, that practitioner could face disciplinary action by the Board. Practitioners understand, both ethically and professionally, that there must be a limitation on practice based on their field of knowledge, particular expertise, and range of ability and training.

Spinal Manipulation: Risk of Harm

Spinal manipulation is a technique used by healthcare professionals to, among other things, aid in the reduction of pain, increase motion and enhance one's mobility. Whenever there is a technique that is perceived as carrying "risk", one needs to assess the actual risk of harm that the technique presents. In the area of spinal manipulation, there is a perceived risk of neurovascular disruption, with subsequent deficits, that can occur during or after the manipulative procedure. In the absence of rigorous, well-controlled studies, one must rely on case reports that are in the literature to determine if a trend exists in regards to the harm that has been associated with manipulative procedures performed by various healthcare professionals.

Anatomical Basis for Potential Harm: Cervical Region

Regarding risk of harm, the primary anatomical structures of concern are the vertebral arteries (VA). The vertebral arteries course through the vertebral foramen. The location of the foramena that houses the vertebral arteries in the cervical region is illustrated below.



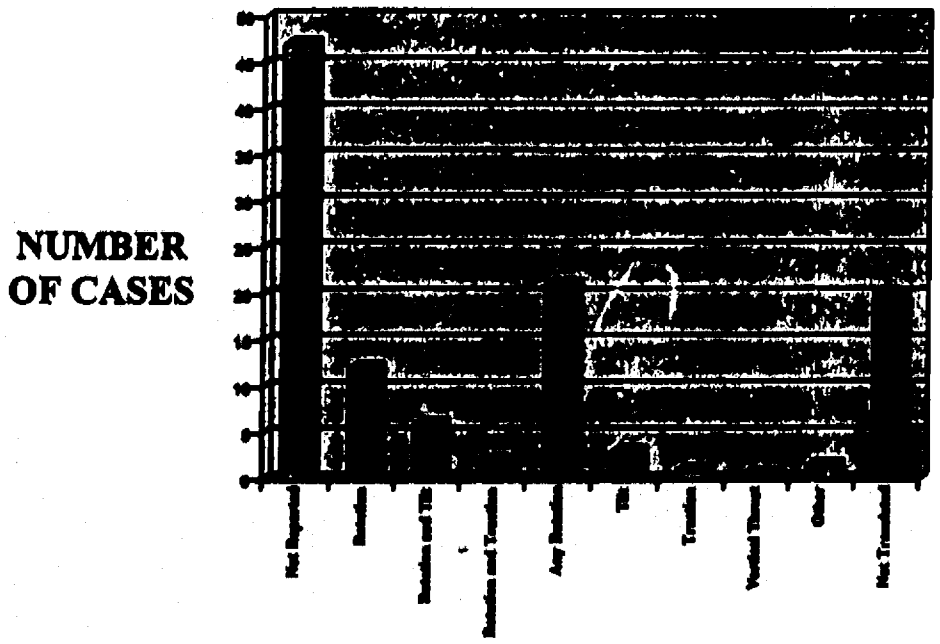
From: http://numedsun.ncl.ac.uk/~nds4/tutorials/column/text/1c.html

The vertebral arteries, at their termination, join together to form the singular basilar artery. Prior to this, the right and left posterior inferior cerebellar arteries (PICA) branch off the left and right VA's respectively. The basilar artery and its subsequent branches are important in supplying blood to the posterior portion of the brain and the brainstem itself. Disruption in this circulatory structure can result in symptoms that include, but are not limited, to the following: dizziness, visual deficits, dysarthria, dysphagia, ataxia, impaired sensation, impaired motor function and nystagmus.[1] In extreme cases, death can result from disruption of the vertebrobasilar system.

Vertebrobasilar accidents that result in ischemic episodes are often associated with one of the following mechanisms: compression and/or stretching of the VA wall, intimal tear with clot formation, intimal tear with embolic formation, vessel wall disruption with subintimal hematoma, vessel wall dissection with pseudoaneurysm formation or perivascular bleeding.

The majority of incidences of injury resulting from spinal manipulation have been reported in case study format. Consequently, specific information about the exact mechanism of injury to the vertebrobasilar system as a result of spinal manipulation is limited. The following is a graph depicting the type of cervical spine manipulation that resulted in injury: (In 24% of the reported cases, the type of manipulation was not identified because the original article was not published in

English and the description of the manipulation was missing from the secondary source interpretation or the English-language abstract.)



Adapted from: DeFabio, R.P., *Manipulation of the cervical spine: Risks and benefits.* Physical Therapy, 1999; 79(1):50-62.

Injury resulting from spinal manipulation was reported as early as 1934.[1] There are case reports in the literature describing the occurrence of vascular compromise of the vertebrobasilar subsequent to cervical spine manipulative procedures. In 1977, Easton and Sherman reported two cases of cerebrovascular accident as a result of chiropractic manipulation.[3] In 1991, Frisona and Anzola reported three cases whereby patients suffered vertebrobasilar strokes as a result of chiropractic manipulation.[4] In 1993, Sinel and Smith provided a case report of a 32 year old female who suffered a thalamic infarct as a result of spinal manipulation that involved high velocity head turning.[5] Terret and DiFabio have done extensive literature reviews in the area of injury resulting from spinal manipulation.[1,2]

In his article entitled, "Manipulation of the Cervical Spine: Risks and Benefits," Richard Di Fabio studied 177 published cases of injury reported in 116 articles between 1925 and 1997. The most frequently reported injuries involved arterial dissection or spasm and lesions of the brain stem. Physical therapists were involved in less than 2% of the cases, and no deaths were attributed to manipulation of the cervical spine by physical therapists.

Limitations in Present Research:

The research that has been done to date, as indicated previously, primarily involves case reporting. In the majority of cases valuable information is lacking in regards to the following:

1. Type of clinician
2. Experience of clinician
3. Patient's past and present medical history
4. Type of manipulative procedure

The following is a chart of "clinician type" derived from the 180 cases (sometimes the same case was reported multiple times, though an attempt was made to eliminate the redundant cases) reported by Terret[1]:

Chiropractor / Chiropractic	Medical Practitioner	Osteopath	Physio-therapist	Other	Unknown
103	27	13	6	13	21

*Other category includes: self, wife, kung fu practitioner, barber, lay practitioner, naturopath and kinesiotherapist

Terrett has also "corrected" the identity of the practitioner if it was reported to be a chiropractor, but from his research, the report contained inaccurate descriptions of the practitioner. In some cases, therefore, the practitioner originally identified as a chiropractor was changed to another type of practitioner. In 50 of the 78 cases that resulted in significant disability and/or death, he has identified the treating clinician as a chiropractor. Three out of seventy-eight were attributed to intervention performed by physical therapists, and two of those occurred in South Africa and New Zealand. *

Injury Occurrences Independent of Spinal Manipulation:

There have also been occurrences of vertebrobasilar strokes independent of spinal manipulation procedures. In 1973, Nagler reported three cases whereby vertebral artery obstruction occurred as a result of neck hyperextension during activities which included gymnastics, calisthenics and yoga.[6] Additionally, in 1977, Easton and Sherman reported a stroke that occurred while head turning during driving.[3] Terrett reports additional occurrences of stroke related to head/neck rotation and/or extension, independent of spinal manipulation. In the cases reported, head movement occurred during activities such as neck extension for a nosebleed, archery, star gazing, rap dancing and sleeping.[1]

Malpractice Reports:

Maginnis and Associates, the group that provides Professional Liability Insurance for physical therapists through the American Physical Therapy Association (APTA), has reported that no specific losses can be attributed to "manipulation or high velocity thrust". A memorandum written in May of 1996 from Judith Cipriano, the Director of Property and Casualty Product Development stated that they were "not able to find a single claim with this allegation."

In a memorandum written in March of 1999, the Underwriting Manager for CNA Health Pro reported to the APTA that they had conducted a review of their national claim file (approximately 600 claims) and found only three claims that mentioned manipulation. Two claims occurred in

1993; one was closed with no payment. One claim was filed in 1997; they did not report whether a payment was made. All three involved manipulation of the neck, and none of these claims occurred in Virginia.

In a commentary written in the Journal of Manipulative and Physiological Therapeutics in 1997, Jagbandhansingh indicates that between 1991 and 1995, the National Chiropractic Mutual Insurance Company paid over 73 million dollars for 1,403 losses at an average of $52,000 per case (ref).[7] The most common malpractice claims reported between 1991 and 1995 are identified in the table below:

MALPRACTICE CLAIM	PERCENT OF CASES
Disc Problems	26.7 %
Fractures	13.8%
Failure to Diagnose	13.1%
Aggravation of Prior Condition	7.1%
Cerebrovascular Accident	5.4%
Burn	3.4%
Therapy	3.0%

From: Jagbandhansingh, MP. Most common causes of chiropractic malpractice lawsuits. *Journal of Manipulative and Physiological Therapeutics*. 1997;20(1):60-63.

Ruling by the Health Care Financing Administration

It had been reported that the Health Care Financing Administration (HCFA) would no longer cover manipulation of the spine if the services were provided by a physical therapist. In a letter from Dr. Thomas Gustafson, Director of Plan and Provider Purchasing Policy Group dated July 21, 1999, he has stated that that is not the case and a clarification of HCFA's position was provided. Section 1852 (a) of the Social Security Act requires Medicare managed care plans to provide all Medicare services, including physician services, to their Medicare enrollees. Accordingly, plans must make available to patients physicians, which includes chiropractors, to deliver manual manipulation of the spine to correct a subluxation. Managed care plans may also use physical therapists to provide services, including manipulative treatment of the spine and other areas, as long as physicians are included and they do not rely only on non-physician practitioners to provide services under the plan.

It was further noted that the HCFA policy is applicable to managed care plans only and has no implications for fee-for-service Medicare. Dr. Gustafson reported that there is no intention on the part of HCFA to introduce additional restrictions on which professionals can bill for manipulative treatments.

Studies and Actions from Other States

As a result of legislation introduced in the New York, the State Education Department's Office of the Professions, which is authorized to regulate 38 professions, including chiropractic, medicine, and physical therapy, conducted a lengthy process of research, analysis and debate on the issue of spinal manipulation. Information about spinal manipulation was obtained from health literature,

criteria of national accrediting bodies, national examination blueprints, and statutes of other states. All the data was sent to the Department's counsel with a request for a legal opinion. Findings of the report were as follows:

- Course content on manipulation must be included in the curricula of every physical therapy program accredited by the Commission on Accreditation in Physical Therapy Education.
- The National Physical Therapy Examination, used as the licensure examination for physical therapy, identifies spinal manipulation as an area to be tested.
- Literature supports physical therapists' historic experiences with manipulation, while numerours letters from physicians indicate that physical therapists are performing spinal manipulation with skill and expertise and have been for many years.
- Agreement was reached among the representative chiropractic and physical therapy members of a joint practice committee meeting that what physical therapy refers to as "Stage V Mobilization" is synonymous to what chiropractic describes as "manipulation," that is, movement of joint beyond the elastic barrier without destroying the integrity of the joint structure.
- Definitive evidence was not found to support the position that physical therapists' use of manipulative procedures poses a greater risk to the public's health and welfare than from chiropractors performing this procedure.

The subsequent opinion of the Office of Counsel stated that the law clearly authorizes physical therapists to perform spinal manipulation and/or spinal mobilization and has done so for at least nineteen years. Manipulation was determined to be an activity that can be performed under the heading of physical and mechanical means.

With regard to individual competence to perform spinal manipulation, it is unprofessional conduct in New York for a licensee to perform professional responsibilities which the licensee knows she or he is not competent to perform. Whether a practitioner is a physical therapist, a physician, or a chiropractor, licensees could be charged with unprofessional conduct if they undertake to perform tasks for which they are not competent by education, training or experience, even if those tasks are within their legal scope of practice.

The chiropractic profession has been actively engaged in seeking restrictive legislation on the practice of spinal manipulation. While bills have been introduced in a number of states to restrict the practice of manipulation, most have died in committee; others have been defeated by the legislature or are still under consideration. In several cases, efforts to restrict manipulation have resulted in changes to state practice acts. In North Carolina, physical therapists are precluded from performing manipulation of the spine, unless prescribed by a physician (in Virginia, all physical therapy is performed under the direction and referral from a physician). In West Virginia, the chiropractic practice act limits spinal manipulation to licensees that have received a minimum of 400 hours of classroom instruction and a minimum of 800 hours of supervised clinical training at a facility where spinal manipulation is a primary method of treatment. The state of Florida has adopted a statute stating that physical therapy practitioners are not authorized to practice chiropractic medicine, including specific spinal manipulation. Arkansas, Iowa, Minnesota, Nevada, Utah, and Washington also have some restriction on the practice specified in law.

Under-girded by a policy statement on spinal manipulation urging the profession to "protect the art as uniquely chiropractic", which was adopted by the American Chiropractic Association (ACA) at its annual meeting in August, 1999, legislative efforts are likely to continue.

REVIEW OF DISCIPLINARY CASES IN VIRGINIA

In making a determination on regulation of any profession, the primary issue is always the protection of public and safety. Before any consideration is given to restricting the current scope of practice for any licensed profession, there should be evidence that the public is not being adequately protected. To make that determination on harm to the public, a report was prepared on Complaints, Violations, Sanctions for Chiropractors, Physical Therapists, Physical Therapist Assistants (1991 - 1998) - See attachment.

In addition, the Department conducted a review of all complaints for Chiropractors and Physical Therapists (including those which did not result in a disciplinary case):

Total number:
649 complaints filed
537 complaints against chiropractors
112 complaints against physical therapists

Of the 112 physical therapy complaints, 68 involved either unprofessional conduct or standards of care. All of those case files were reviewed by a researcher for any complaints involving spinal manipulation. The finding was that: **No case has ever been documented in Virginia against a physical therapist performing spinal manipulation (or mobilization).** (All cases in which there was any mention of the words "manipulation" or "spine" were specifically copied and also reviewed by Dr. Warren Koontz, Executive Director of the Board of Medicine.)

SUMMARY OF PUBLIC COMMENT ON STUDY

Comments received in writing on the study included the following:

The position of the Virginia Physical Therapy Association is that there is no evidence that manipulation by a Virginia licensed physical therapist has resulted in patient complications and that any legislation to restrict their practice is unnecessary.

A physical therapist wrote that the "force, amplitude, direction, duration, and frequency of manipulative treatment or spinal manual care are discretionary decisions made by the physical therapist on the basis of education and clinical experience and on the individual patient's profile and are within the scope of practice of what physical therapists are qualified to do."

A recent graduate of Shenandoah University's masters level program in physical therapy wrote to say that she has been comprehensively educated to specialize in manual therapy for all joints of the body. Without the ability to treat the spine, physical therapists would be neglecting a huge component of musculoskeletal injuries.

A medical doctor, a rehabilitation specialist, board-certified in physical medicine wrote to say that the physical therapists to whom he refers patients are well-versed in spinal manipulation and should have full privileges to treat patients with biomechanical dysfunctions. These therapists have taken extensive course-work in high-velocity, low-amplitude techniques, muscle energy techniques, strain/counterstrain and soft tissue mobilizations.

A physical therapist wrote to express concern over the possibility of limiting the current scope of practice. He points out that joint manipulation is often necessary to ensure that a stiff joint can move through its full range of motion.

A chiropractor who is a delegate to the American Chiropractic Association wrote to explain that a ACA committee has been formed to develop data on Spinal Manipulative Therapy (SMT) and that in its opinion, SMT is a chiropractic science and art that should be a physician-applied service provided only by trained and qualified specialists.

The Virginia Society of Chiropractic noted that medical doctors receive no training in spinal adjustive procedures and recommended that "only Doctors of Chiropractic and Osteopathy, when a) properly trained as part of their core curriculum, including faculty observed clinical training and b) licensed in the Commonwealth, are qualified to perform their profession-specific spine procedures."

The position of the Virginia Osteopathic Medical Association is that Doctors of Osteopathy should not be included in any language that defines the type of manipulation that is being performed or provides any hourly requirement or restriction.

RECOMMENDATION OF THE BOARD OF MEDICINE:

In § 54.1-100, it is stated that every person has a right to engage in any lawful profession and that the Commonwealth cannot abridge such right except as a reasonable exercise of its police powers when it is clearly found that such abridgment is necessary for the prese"/ation of the health, safety and welfare of the public. No regulation is to be imposed on a profession except for situations in which the unregulated practice of the profession can harm or endanger the public and the potential for harm is recognizable and "not remote or dependent upon tenuous argument."

The Board of Medicine considered the content of the report on spinal manipulation as developed by the Task Force and voted 11-5 to accept the report with the following recommendation:

In the opinion of a majority of the Board of Medicine, no evidence has been presented to suggest that additional statutes or regulations are necessary to protect preserve the health, safety and welfare of the public. In fact, there is evidence that the public has not been harmed or endangered by physical therapists who practice spinal manipulation and that the potential for harm is remote. Therefore, the report of the Board to the Chair of the Senate Committee on Education and Health is that legislation such as proposed by Senate Bill 600 in 1998 and Senate Bill 1141 in 1999 is both unnecessary and unwarranted and that there should be no limitations placed on the professions that currently utilize manual spinal care or spinal manipulation within their scope of practice. X

References

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4. Frisoni GB, Anzola GP. Vertebrobasilar ischemia after neck motion. *Stroke*. 1991;22:1452-1460.

5. Sinel M, Smith D. Thalamic infarct secondary to cervical manipulation. *Arch Phys Med Rehab*. 1993;74:543-546.

6. Nagler W. Vertebral artery obstruction by hyperextension of the neck: report of three cases. *Arch Phys Med Rehab*. 1973;54:237-240.

7. Jagbandhansingh, MP. Most common causes of chiropractic malpractice lawsuits. *Journal of Manipulative and Physiological Therapeutics*. 1997;20(1):60-63.

The University of The State Of New York
THE STATE EDUCATION DEPARTMENT

To: Norman Cohen and Barbara Zittel

Date: April 23, 1999

From: Johanna Duncan-Poitier

Subject: Physical Therapy and Spinal Manipulation

I am writing to officially describe the State Education Department's legal interpretation of relevant law concerning whether physical therapists may legally perform spinal manipulation as part of their statutory scope of practice. The question emerged when legislation was introduced that proposed to limit the activity to chiropractors and physicians.

The Department responded to this question through a lengthy process of research, analysis and discussion. In addition to an extensive review of the Education Law, information about spinal manipulation was obtained from such sources as bill jackets, health care literature, the criteria of national accrediting bodies, national examination blueprints, and the statutes of other states. In addition to obtaining information from all of the members of the State Boards for Chiropractic and Physical Therapy, a joint committee meeting was held with representative members of these Boards, legal and other staff including both of the Executive Secretaries, the Coordinator of Professional Practice, the Executive Director of Professional Responsibility and me. We officially provided the information presented at that meeting as well as all other gathered data to the Office of Counsel and requested a legal opinion regarding spinal manipulation in relation to the scope of practice of Physical Therapy.

We have recently received that opinion, which states that Section 6731 of Article 13-5 of the Education Law clearly authorizes physical therapists to perform spinal manipulation and/or mobilization and has done so for at least nineteen years.

An important reminder is required concerning individual professional competence. Part 29.1 (b)(9) of the Rules of the Board of Regents, states that it is unprofessional conduct for a licensee to accept and perform professional responsibilities which the licensee knows that she or he is not competent to perform. Whether the practitioner is a physical therapist, a physician, or a chiropractor, licensees must not undertake to perform tasks that they know they are not competent to perform by education, training, or experience, even if those tasks are within the legal scope of practice of the respective profession.

I want to thank you and the members of the Chiropractic and Physical Therapy Boards for unwavering dedication to this issue, for perseverance and for patience throughout the process. The determination of the practice will be posted on our web site. I ask that you also disseminate this information to your Boards and other interested parties.

C: Kathy Ahearn
Frank Munoz
Fred Burgess
Doug Lentivech
Doug Lord

fsbpt

Mr. Jack McDonald
Attorney at Law
North Dakota State Examination Committee
For Physical Therapy
220 North 4th Street,
Bismarck ND 58502-2056

26 February 2003

Dear Mr. McDonald,

This letter is in response to a request from the North Dakota State Examination Committee for Physical Therapy that I review all of the complaints in the Federation Disciplinary Data Base to determine if any claims had ever been filed against a physical therapist for malpractice or negligence relating to the use of spinal manipulation.

Our data base is made up of all of the Health Integrity and Protection Database (HIP DB) complaints that are filed through our office as an agent of the HIP DB and those complaints that states, not using us as a reporting agent, report directly to the government. In other words all of the disciplines that meet the HIP DB threshold are in the data base that we maintain.

Our data base goes back to 1996 and the manager of the data base just completed a review and reported that there are no cases of malpractice or neglect related to spinal manipulation. I have personally read every final order since I became Director of Professional Standards in 2000 and I can state factually that there has never been a final order concerning a physical therapist and the use of manipulation as a therapeutic modality. Most disciplinary cases, as with all medical professions, relate to unprofessional conduct, drug and alcohol abuse and improper supervision.

I hope that this information is helpful to you. If you need any additional information please do not hesitate to contact me.

Sincerely,

Christine A. Larson

Christine A. Larson, PT
Director of Professional Standards

FEDERATION OF STATE BOARDS OF PHYSICAL THERAPY
509 WYTHE STREET, ALEXANDRIA, VIRGINIA 22314 | 703.299.3100 PHONE | 703.299.3110 FAX
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CNA

CNA Plaza 240 Chicago IL 60685-0001

Michael A. Scott
Assistant Vice President
Medical Professional Liability
Telephone 312-822-7449
Facsimile 312-817-1972
Internet michael.scott@cna.com

February 12, 2003

Ms. Jennifer Baker
Manager Insurance and Member Benefits Services
American Physical Therapy Association
1111 North Fairfax Street.
Alexandria, VA 22314-1488

Re: Manipulation Claims

Dear Jennifer:

CNA has been the underwriting company for the APTA-endorsed physical therapy professional liability insurance program, offered by Healthcare Providers Service Organization, since 1992, and is responsible for managing reported claims.

After review of our claims database, which includes approximately 1000 open and closed claims involving insured physical therapists, we have not identified any trends relative to manipulation that would indicate this procedure presents a risk factor that we need to be specifically concerned about. *

Further, we currently do not anticipate any impact to claims or rates in this program related to physical therapists performing manipulation.

Please note that all findings stated herein are based solely upon CNA specific claim data.

Sincerely,

Michael A. Scott

cc: Linda Cobble-Bell/CNA
Scott Kelley/AIS

DPT Curriculum

YEAR 1

Fall

PTH 409	Kinesiology	5
PTH 407	Physiology of Rehab	3
PTH 411	Principles of PT	3
PTH 405	Anatomy	6
PTH 415	Evidence Based Pra I	1
	Semester credits	**18**

Spring

PTH 452	Physical Assessment	5
PTH 438	PhysicalAgents&mass	4
PTH 450	Pharmacology	3
PTH 436	Therapeutic Ex	3
PTH 434	Neuro Science	3
	Semester Credits	**18**

May/June

PTH 530	Patient Care	2
PTH 552	MS Assesment	3
PTH 554	Pathophysiology	3
	Semester Credits	**8**

July/Aug

PTH 501	Clinical Ed (6 wks)	4

YEAR 2

Fall

PTH 623	Motor Control	3
PTH 615	Research	2
PTH 631	Cardiopulmonary I	3
PTH 635	Integumentary Mgt.	3
PTH 612	Advanced Ortho I	4
PTH 627	Psychosocial Asp	2
	Semester Credits	**17**

Spring

PTH 632	Cardipulmonary II	3
PTH 624	Neuro Rehab	3
PTH 642	Administration	4
PTH 644	Principles of Aging	3
PTH 636	Women & Men Hlth	2
PTH 638	Pediatrics	3
	Semester Credits	**18**

May/June

PTH 700	Clinical Ed II 8 wks	6
	SemesterCredits	**6**

July/Aug

PTH 721	AdvancedOrtho II	3
PTH 751	Radiology	3
	Semester Credits	**6**

YEAR 3

Fall

PTH 815	Evidence Based Pra III	2
	Elective	2 or 3
	Elective	2 or 3
PTH 801	Leadership Sem	3
PTH 805	Adv. PT Mgmt. Sem	4
	Semester Credits	**15**

Spring

PTH 850.1	Clinical Ed III 8 wks	6
PTH 850.2	Clin Ed IV 8 wks	6
	Semester Credits	**12**

Total Credits 122

CURRICULUM DESCRIPTIONS

PTH 409 Kinesiology and Pathomechanics
(4 hour lecture/2 hours lab per week)

This course covers the study of joint and muscle function applying the principles of biomechanics and motion to both normal and pathological populations including gait and gait analysis, posture and posture analysis and goniometry. Palpation of surface anatomy, application of biomechanical theory and muscle function to normal and pathological movement is the basis for laboratory study on human subjects. Students compare pathological movement to normal and analyze the probable causes.

PTH 405 Gross Anatomy and Histology
(4 hours lecture; 4 hours lab)

A detailed study of bony landmarks and musculoskeletal system of the human body underlying physical therapy assessment and intervention. Gross anatomy includes examination of the anterior and posterior abdominal wall, the superficial and deep back muscles, lower extremities, head and neck, upper extremities, and thoracic organs. The histological structure and development of the musculoskeletal, connective tissue, integumentary, vascular and respiratory systems will be examined.

PTH 411 Principles in Physical Therapy
(3 hours lecture)

Program in Physical Therapy - University of Mary - 7500 University Drive - Bismarck, ND - 58504
1-800-408-6279 - 701-355-8053

This introductory course stresses transcurricular components of the curriculum. Because this is a first-semester, first-year course, all elements are introduced to provide the students with the knowledge to integrate the skills learned into the remainder of the curriculum. These components are covered under the major areas of communication (written and oral), teaching/education in physical therapy, and professional development. Professionalism, safety, legal issues, ethics, prevention and wellness, Benedictine Values, teaching diversity and rural issues are the transcurricular components that will be introduced in this course.

PTH 407 Physiology of Rehabilitation
(3 hours lecture)

The physiology of the neurological, musculoskeletal, cardiopulmonary, and renal systems is the focus of this class. Special emphasis is given to the functions of the neurological and musculoskeletal systems during exercise and motor control. Intermediary metabolism is presented in terms of the conversion of chemical energy to mechanical and heat energy during exercise. Oxygen and carbon dioxide transport in healthy and sedentary/pathology subjects is presented in relationship to diffusion capacity, blood flow changes, work capacity, and training adaptations. Special attention will be given to the response of the heart during exercise and blood pressure changes. The pulmonary and renal regulation of total body acid – base will also be a focus of this course.

PTH 415 Evidenced Based Practice I
1 credit (1 hour lecture per week)

The concept of evidenced – based practice is presented within the context of the examination, evaluation, diagnosis, intervention, prognosis, and outcomes (Physical Therapy Practice Management Model). The use of classical and clinical research designs and databases are presented as the tools to produce the evidence component of evidenced – based practice. An introduction to the components of research manuscripts/publications; and the elements of qualitative and quantitative (statistical) analyses will also be presented.

FIRST YEAR SECOND SEMESTER

PTH 452 Physical Assessment
5 credits (4 hours lecture; 2 hrs lab)

Physical examination and screening for the neurological, muscular, skeletal, cardiovascular, endocrine and integumentary systems, and the determination of a differential physical therapy diagnosis will be addressed. The course covers the identification, selection, prioritization of clinical signs and symptoms in order to integrate them for the purpose of clinical diagnosis. The content is applied to preparing the student for primary care patient situations as a basis for evaluating and interpreting assessment data and determining the indications and contraindications for physical therapy treatment and patient referral to other practitioners.

PTH 438 Physical Agents & Massage
4 credits;
(3 hours lecture; 2 hours lab)

The course will emphasize the theory, indications, contraindications, clinical decision making, and the safe application of physical agents including heat, cold, hydrotherapy, electrotherapy, traction, compression, and massage.

PTH 450 Pharmacology 3 credits
(3 hours lecture)

A course covering basic pharmacotherapeutics, including the pharmacokinetics and the pharmacodynamics of drugs relevant to physical therapists. New drugs will be identified with special emphasis on their effects on PT interventions. This course will present some of the basic drug classes and their physiologic basis of action. Drugs will be grouped according to their general effects and the type of disorders they are routinely used to treat that are commonly used to treat sports related injuries and disease processes. This course will address how drug therapy interacts with physical therapy and how drugs can exert beneficial effects as well as adverse side effects that impact on rehabilitation.

PTH 436 Therapeutic Exercise 3 credits
(2 hours lecture; 2 hours lab)

This course introduces the student to the theory and practice of therapeutic exercise including active and passive range of motion, proprioceptive neuromuscular facilitation, stretching, joint mobilization, strengthening, and aerobic exercises.

PTH 434 Neuroscience 3 credits
(2 hours lecture; 2 hours lab)

Program in Physical Therapy - University of [redacted] - 7500 University Drive - Bismarck, ND - 58504
1-800-408-[redacted] - 701-355-8053

A detailed study of the central and peripheral nervous systems of the human body. Neuroscience includes the study of the cell biology and development of the nervous system, examination of the vascular and CSF systems, sensory and motor pathways, and the neurophysiology of the central nervous system.

FIRST YEAR MAY/JUNE SESSION

PTH 530 Patient Care 2 credits:
(4 hours lecture/2 hours lab per week during 8 week term)

This course prepares the student in the principles of body mechanics and safety precautions, transfers of patients, positioning and draping, wheelchair fitting and mobility, ambulation with assistive devices, infection control, bandaging, initial wound care, and introduction to orthotic devices. This course is also the final step in preparation for the student's first clinical educate experience The Benedictine values of respect and the University competencies of Physical Environment, Professional Development, and Valuing are emphasized

PTH 552 Musculoskeletal Assessment
3 credits (4 hours lecture; 4 hours lab per 8 week term)

The course is an introduction to orthopaedic evaluation skills in neuromusculoskeletal.. Emphasis focuses on basic evaluation techniques in orthopedic and manual physical therapy with an introduction to functional rehabilitation. It provides the foundation for selection of appropriate assessment and treatment planning. Students learn an algorithm approach to screening, examination, and evaluation which all involve a critical thinking process to establish an orthopedic physical therapy diagnosis.

PTH 554 Pathophysiology 3 credits
(6 hours lecture per week)

Pathological conditions as they relate to differential diagnosis in physical therapy. The course is an overview of the normal and common pathological conditions of the major systems of the body, including the endocrine, cardiovascular, reproductive, immune, nervous, gastrointestinal, liver, pancreas, urinary tract, skin, musculoskeletal, fluid and hemodynamic, hematopoietic, respiratory, eye and ear systems. Course content also covers cell pathology, tumors, and recognition of common pathological conditions, and when musculoskeletal symptoms may be related to disease.

FIRST YEAR JULY/AUGUST

PTH 501 Clinical Education I (4 credits)

Each student will be placed in a setting for a 6 week clinical experience. This experience will be in an area emphasizing rural practice, general outpatient, acute care, or a combination. The student will begin to integrate academic knowledge with clinical practice.

SECOND YEAR FALL SEMESTER

PTH 623 Motor Control 3 credits
(2 hours lecture; 2 hours lab)

This course consists of the issues and theories of motor control and motor learning. Students will build on their knowledge of physiology of motor control by applying this knowledge to clinical practice. Included in the course with be both abnormal and normal postural and motor control of both upper and lower extremities.

PTH 612 Advanced Orthopedics I 4 credits
(3 hours lecture; 2 hours lab)

This course emphasized the patient/client clinical management following a thorough examination, evaluation, and differential diagnosis of nouromusculoskeletal impairments. Particular emphasis is placed on the prognosis, intervention, and outcomes of neuromusculoskeletal conditions for conservative and post-operative orthopedic conditions of the upper and lower extremities. Special attention is applied to the on field management of the athlete including advanced evaluation, diagnosis, conditioning, performance enhancement, and treatment techniques using the sports medicine model. Additionally, the advanced evaluation and intervention through manual therapy are addressed including soft tissue and joint mobilization/manipulation of the upper and lower extremities. This course also exposes the students to the medical management of orthopedic conditions through the perspective of area physicians.

PTH 615 Evidence Based Practice II:
The Plan -- 2 credits (2 hours per week)

The course will present the components of a plan for the student's research topic, the Research Proposal. The student will select a research topic related to physical therapy practice; students then provide background and

justification for the topic, and a plan for data collection and analysis in a written proposal. The proposal is also presented to peers and faculty as an oral presentation. The course will also include a case – based statistical analysis laboratory in which the student will write the hypotheses for the cases, perform the appropriate statistical analysis, and write their conclusions in terms of applying the results to practice. Ethical considerations of authorship, the protection of subjects' rights, and the institutional review process will also be presented using a case – based approach.

PTH 631 Cardiopulmonary I 3 Credits
(2 hours lecture; 2 hours lab per week)
This course will present the central and peripheral cardiovascular system in a cellular through system format. Emphasis will be placed on the specificity of anatomic location and cellular function of the structures and the relationship between that function and circulatory systemic responses and physiologic ventilatory and respiratory systemic responses. Emphasis will be placed on the specificity of anatomic location and cellular function of the structures and the relationship between impairment and function. Use of the electrocardiogram for baseline testing and subsequent monitoring will be presented to include both test performance and clinical utilization. Focus will be on recognition, interpretation and application. Use of pulmonary function tests, arterial blood gas analysis, oximetry and expired gas analysis will be presented to include both test performance and clinical utilization.

PTH 627 Psychosocial Aspects of Pt Care
2 credits (2 hours per week)
This course involves a weekly meeting by all members. It includes didactic and student presentations (15 minutes) of his or her experience and evaluation of an interview with a disabled person. The course addresses the psychological and psychosocial problems associated with chronic disease, traumatic injury and being in the "patient role."

PTH 635 Integumentary Mgmt. 3 credits
(2 hours lecture; 2 hour lab per week)
This course will concentrate on the examination, evaluation, diagnosis, prognosis, plan of care, and intervention of wounds as well as amputation/prosthetic care. The student will synthesize the knowledge of the disease process with rehab management. The student will collaborate with podiatrists and prosthetists and will gain hands-on experiences working with patients with wounds and amputations.

SECOND YEAR SPRING SEMESTER

PTH 632 Cardiopulmonary II 3 credits
(2 hours lecture; 2 hours lab)
The multi-system impact of bed rest and reconditioning will be presented and discussed to include consideration of normal individuals and those with diagnosed system pathology. Pathophysiology and examination of acute and chronic pulmonary conditions that impact airway management, airway clearance and gas exchange (pneumonia context of multiple-system impairment issues and specificity of training outcome. Techniques of exercise testing from maximum testing of healthy individuals through clinical assessment of multiply impaired patients will be presented. A review of the protocols in the literature will focus on reliability, validity and utility of these protocols. Lab familiarization and practice with equipment and protocols to include: maximal exercise testing. 6 minute walk testing, exercise testing with multiple equipment types and protocols. Exposure to and practice with oxygen delivery equipment, ventilatory muscle testing and training equipment, suction equipment and mechanical ventilators.

PTH 624 Neurological Rehab 3 credits
(2 hours lecture; 2 hours lab)
Concepts and principles in the examination, evaluation and ethical and collaborative treatment and care plan of the adult neurologically involved client. Students use case studies to manage various neurological conditions and use simulated conditions to develop therapeutic techniques for use in treatment of such conditions., COPD, atelectasis, asthma, chest trauma, pneumo/hemothorax, lung contusion, TB, cancer) will be presented including etiology, invasive and non-invasive tests and measures, and common medical/surgical interventions. The principles of training will be considered within the

PTH 642 Administration 4 credits
(4 hours lecture per week)
In this course, the students study the healthcare system and the role of the Physical Therapist in the healthcare system. Students examine

various payment systems, and their impact on the healthcare delivery. Students explore different personal management styles, human resource management, financial management, and program development. They will also learn record keeping, liability, malpractice, consultation, and professional communication. Additional ethical, legal, and practice issues will also be discussed on an asynchronous discussion board.

PTH 644 Principles of Aging 3 credits
(3 hours lecture)
This course provides an introduction to current concepts and issues that impact health care delivery for the older adult population. Theory of normal aging processes, sociocultural, environmental factors, psychosocial issues, and musculoskeletal/neuromuscular changes are discussed in relation to health promotion, prevention and wellness, optimal daily function, and quality of life. Collaboration with other health care providers, community, and family resources will be addressed. The Benedictine values, particularly respect for person and hospitality are stressed as essential to the development of a therapeutic environment. A service learning component is included to offer the student a "hands-on" opportunity to work with an elderly person while also developing a relationship with and assisting the person to achieve a healthy lifestyle.

PTH 636 Women's and Men's Health
2 credits (2 hours lecture; 1 hr lab per week)
While many of the conditions discussed in this class are typically considered "women's problems", this class will also emphasize the necessity of awareness of problems for men. Starting with an overview of health concerns in the young, we will also explore health problems in the "child-bearing" years and health concerns as we age. The student will learn examination, evaluation, diagnosis, prognosis, plan of care, and intervention of musculoskeletal concerns in pregnancy, pelvic floor dysfunction, and breast cancer care. The student will also learn the importance of community education and marketing.

PTH 638 Pediatrics in Physical Therapy
3 credits (3 hours lecture per week)
Pediatric Physical Therapy is a course covering normal and abnormal physical and motor development, common pediatric conditions, therapeutic theory and technique, adaptive equipment and devices, synthesis of knowledge into management of a pediatric condition, and ethics, and collaboration with other professionals for development of a plan of care.

[redacted] SECOND YEAR: MAY/JUNE [redacted]

PTH 700 Clinical Education II 6 credits
(8 weeks clinical education experience)
The 8 week clinical education experience will provide the student the opportunity to practice and gain further experience in content areas of advanced orthopedics, neurological rehabilitation, pediatrics, manual therapy, cardiac rehabilitation, rural or burn/wound therapy.

SECOND YEAR: JULY/AUGUST

PTH 721 Advanced Orthopedics II 4 credits
(4 hour lecture/4 hours lab per week in the 8 week term
This course emphasized the patient/client clinical management following a thorough examination, evaluation, and differential diagnosis. Particular emphasis is placed on the prognosis, intervention, and outcomes of neuromusculoskeletal conditions for conservative and post-operative orthopedic conditions of the spine. Special attention is place on the workplace management of the industrial athlete including advanced evaluation, diagnosis, conditioning, performance enhancement, and treatment techniques. Additionally the advanced evaluation and intervention of manual therapy are addressed including soft tissue and joint mobilization/ manipulation of the spine. This course also exposes the students to the medical management of orthopedic conditions through the perspective of area physicians.

PTH 751 Radiology 3 credits
(3 hours lecture per week)
Identification of normal and abnormal radiographic findings in spine, thoracic and extremity injuries. Principles of radiographic and other imaging evaluation including MRI, C-Scan, tomography, and bone scans as they apply to physical therapy. Pros, cons, indications and

contraindications of imaging studies will be highlighted. Lecture, case studies.

THIRD YEAR; FALL SEMESTER

PTH 815 Evidence Based Practice III: The Manuscript & Publication 2 credits (2 hours lecture per week)
The students will compose their final research manuscript. The manuscript should be written for submission to a professional physical therapy journal or to a peer reviewed journal in a related field. The organization, style, and ethical considerations of the professional dissemination of research results will be studied using research cases.Students will be required to make a 15-minute oral presentation to the faculty, fellow students, physical therapy clinicians, and other health care professionals at the annual University of Mary Research Colloquium.

PTH 805 Advanced Physical Therapy Management Seminar: 4 credits (Class will meet a total of 60 hours during the semester)
This class is the capstone class for physical therapy management of patient cases. Students will synthesize previous skills from all prior coursework. Special emphasis will be placed on screening for differential diagnosis, management of comorbidities, integration of other diagnostic information (lab, radiological, EKG and EEG, pulmonological studies etc.) Integration of pharmacological side effects will also be considered. This course will be problem based. Students will develop an evidenced based management plan based on their interpretation of screening and examination; integrate the information; and develop a management plan for the patient, which includes all aspects of patient care including treatment, environmental management, including home, work, social, and physical environments, and consideration of any ethical or legal implications.

PTH 801 Leadership Seminar: 3 credits (4 week seminar) Students will participate in a field work experience that will include an emphasis on service learning, Benedictine values, and the competences of scholarship, valuing, environmental contexts, and professionalism. During this experience, students will work in a rural, 3rd World Country, or foreign environment under the supervision of a clinical instructor. Special emphasis will be placed on students examining the University of Mary components of leadership in these environments.
Electives: 4-6 credits total
Students will have the option of choosing 2 (out of 4 offerings) electives. These electives are beyond entry-level and will help the student explore varying areas of interest. Adjunct faculty clinical specialists will become part of these courses.

THIRD YEAR; SPRING SEMESTER
PTH 805.1 & 850.2
Clinical Education III and IV
6 credits each to total 12 credits
The final two 8 week clinical experiences will continue to progress the student to entry-level. The placements will round out the student's clinical experiences so that the student will have had practice in four diverse settings. The student must be at entry level at the completion of these experiences in order to graduate from the program.

Physical Therapy Professional Program
University of North Dakota

Subject	Contact Hours
Chemistry (pre-PT)	96
Gross Anatomy	252
Neuroanatomy/Neurophysiology	68
General Physiology (pre-PT)	80
Exercise/CardioPulmonary Physiology	68
Acute Care	54
Electrotherapy/Electrodiagnosis	36
Clinical Pathology (orthopedics/neurology)	153
Biomechanics/Kinesiology (orthopedics)	102
Neurology (motor control, neuro-rehabilitation)	170
Examination/Evaluation/Diagnosis	136
Differential Diagnosis	157
Manual Therapy (mobilization/manipulation)	119
Psychology	194
Research	147
Prevention and Wellness	68
Pediatrics	51
Geriatrics	34
Administration and Communication	85
Therapeutic Agents	54
Full Time Clinical Experience	1440

Total Professional Contact Hours = 3360 minimum
(this does not include pre-professional coursework)

Pre-Physical Therapy Requirements

Prior to admission, a minimum of 90 semester hours of credit from an approved college or university is required. Students should be broadly educated in the sciences and humanities. The Department of Physical Therapy recognizes that, since physical therapy deals with people, an understanding of literature, art, history, ethics and philosophy is an adjunct to a physical therapist. Science and humanities are both are viewed as necessary for the practice of physical therapy.

The following list of courses and credits indicates the core prerequisites that all applicants must complete prior to admission to the physical therapy program. It is strongly recommended that students be computer literate prior to entering the professional program. Students may take additional electives from any field of study; however the depth of the pre-physical therapy education should demonstrate that students have progressed from simple to complex studies in at least one content area. This requirement might typically be demonstrated by a discipline major, but in any case should demonstrate a basic comprehensiveness and integrity of study within a particular content area. This does not suggest that a separate undergraduate degree must be awarded, however the breadth and depth in a discipline should be demonstrated. Course credits equivalent to minor (i.e. approximately 20 credits at UND) in a particular discipline could accomplish this requirement. The prospective student should include some credits from upper level courses (i.e. 300 and 400 numbers).

- Two semesters of General Biology (8 cr.)
- Two semesters of General Chemistry (8 cr.)
- Two semesters of General Physics (8 cr.)
- One semester of Human Anatomy (3 cr.)
- One semester of Human Physiology (3 to 4 cr.)
- One semester of Introductory Psychology (3 cr.)
- One semester of Developmental Psychology (3 to 4 cr.)
- One semester of Abnormal Psychology (3 cr.)
- One semester of Introductory Sociology (3 cr.)
- One semester of a Public Speaking course (3 cr.)
- Two semesters of English Composition (6 cr.)
- Arts and Humanities coursework (9 cr.)

All of the prerequisite coursework must be complete before entering the professional program in the Fall semester.

Note: The pre-physical therapy anatomy and physiology help prepare the students for more advanced anatomy and physiology courses within the professional curriculum. The anatomy course would have about 48 hrs. (16 weeks X 3 lecture hours per week) and the physiology course would be about 80 hrs. (16 weeks X 3 lecture hours per week and 2 lab hours a week). The total prePT hours would be 128 hours.

DPT Curriculum – Total Contact Hours = 3360 (minimum)

	Contact Hours
Professional Year 01 – Fall Semester (17 cr.)	
PT 401 .....Intervention Techniques I	68
PT 402 .....Professional Communication and Behavior	34
PT 409 .....Clinical Pathology I	85
PT 422 .....Anatomy for Physical Therapy	204
PT 423 .....Neuroscience for Physical Therapy	68
Total Contact Hours	**459**
Professional Year 01 - Spring Semester (19 cr.)	
PT 410 .....Clinical Pathology II	68
PT 412 .....Biomechanics and Kinesiology	102
PT 413 .....Exercise in Health and Disease	68
PT 415 .....Motor Control	68
PT 417 .....Clinical Examination and Evaluation I	136
PT 426 .....Manual Therapy I	68
Total Contact Hours	**510**
Professional Year 01 - Summer Session (10 cr.) – Graduate School	
PT 512 .....Therapeutic Agents	54
PT 513 .....Intervention Techniques II	54
PT 514 .....Case Management I	36
PT 519 .....Electrotherapy and Electrodiagnosis	36
Total Contact Hours	**180**
Professional Year 02 - Fall Semester (19 cr.) – Graduate School	
PT 520 .....Clinic I: Clinical Practice	720
PT 521 .....Critical Inquiry I	18
Total Contact Hours	**738**
Professional Year 02 - Spring Semester (17-18 cr.) – Graduate School	
PT 522 .....Administration in Physical Therapy	51
PT 523 .....Lifespan I	51
PT 524 .....Psychological Aspects of Disability	34
PT 526 .....Manual Therapy II	51
PT 527 .....Critical Inquiry II	34
PT 583 .....Critical Inquiry III	17
EFR 515 .....Statistics I	51
Electives	34 (minimum)
Total Contact Hours	**323**
Professional Year 02 - Summer Session (9-10 cr.) – Graduate School	
PT 591 .....Critical Inquiry IV	9
PT 592 .....Case Management II	36
PT 562 .....Readings: Physical Therapy	9
Electives	18 (minimum)
Total Contact Hours	**72**
Professional Year 03 - Fall Semester (16-17 cr.) – Graduate School	
PT 511 .....Applied Movement Science/Rehabilitation Procedures	102
PT 525 .....Clinical Examination and Evaluation II	85
PT 539 .....Prevention and Wellness	68
PT 535 .....Lifespan II	34
PT 561 .....Seminar: Physical Therapy	17
Electives	34 (minimum)
Total Contact Hours	**340**
Professional Year 03 - Spring Semester (19 cr.) – Graduate School	
PT 552 .....Clinic II: Clinical Practice	720
PT 995 .....Scholarly Project	18
Total Contact Hours	**738**

COURSE DESCRIPTIONS

101. Orientation to Physical Therapy. 1 credit. Overview of the field of rehabilitation. Survey of the occupational therapist and physical therapist. Films, lectures, and observation in clinical settings.

401. Intervention Techinques I. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Beginning skills for patient management including skills and safety in positioning, draping, therapeutic massage, surface anatomy and an introduction to communication techniques. Laboratory.

402. Professional Communication and Behavior. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Lecture and practice in interprofessional and interpersonal communication including professional behavior, ethics, patient education, scientific writing, and written documentation.

409. Clinical Pathology I. 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Disease groups discussed from all aspects of comprehensive rehabilitation. Included are chronic illness, neurological and orthopedic conditions, general medicine and surgery, pediatrics, geriatrics, and sensory disabilities. In this course students learn general pathology and begin to prepare to differentially diagnose problems.

410. Clinical Pathology II. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Disease groups discussed from all aspects of comprehensive rehabilitation. Included are chronic illness, neurological and orthopedic conditions, general medicine and surgery, pediatrics, geriatrics, and sensory disabilities. In this course learn orthopedic and neurological pathology in preparation for differential diagnosis.

412. Biomechanics and Kinesiology. 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Biomechanics and kinesiology of musculature acting on the extremities and trunk. Theory and techniques of muscle testing and goniometry. Laboratory. In this course students lean applied anatomy, biomechanics, joint structure and function. This course is integral to learning manual therapy.

413. Exercise in Health and Disease. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Lecture and laboratory work to examine and (maintain)/increase mobility, strength, and endurance for healthy individuals and those with disease, with completion of an exercise prescription to address impairments and functional limitations. Functions of the musculoskeletal, pulmonary, and cardiovascular systems will be addressed individually and within their relationships. Laboratory. This course deals with exercise physiology, musculoskeletal function, cardiopulmonary function and is integral to exercise prescription and diagnosis.

415. Motor Control. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Lecture and laboratory work in therapeutic exercise to establish and maintain muscular control and coordination, including muscle re-education, facilitation, and relaxation. Laboratory.

417. Clinical Examination and Evaluation I. 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Emphasizes patient/client management elements of examination and evaluation. Emphasis is given to the musculoskeletal and neurological systems. Laboratory. This course is an orthopedic and neurologic evaluation course. Students learn examination and evaluation skills essential for diagnosis. This course is integral to manual therapy.

422. Anatomy for Physical Therapy. 5 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Detailed lectures and demonstrations on musculoskeletal anatomy and neuroanatomy. Laboratory. This is an advanced anatomy course dealing with musculoskeletal and neuroanatomy. It is the basis for all other examination, evaluation and intervention courses in the curriculum. This course is integral to manual therapy.

423. Neuroscience for Physical Therapy. 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Structure and function of the human nervous system including clinical application relevant to physical therapy practice. This is an advanced neuroscience course which covers neuroanatomy and neurophysiology. Many of the principles taught in this course are applicable to manual therapy as it relates to the spine.

426. Manual Therapy I. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Introduction to joint mobilization with emphasis on peripheral joints. Basic, evaluation treatment techniques and exercises for the lumbar and cervical spine. Laboratory. This is the student's first course in manual therapy techniques and covers the extremities and spine. Emphasis on mobilization with some introduction to manipulation.

490. Special Topics. 1-4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Introduction and investigation of advanced clinical procedures and topics. Topics discussed will be dictated by student and faculty interests.

491. Independent Study in Physical Therapy. 1-4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Research and independent study in a specialized area of Physical Therapy.

511. Applied Movement Science and Rehabilitation Procedures. 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Integration of clinical evaluation, functional goals, and treatment planning for individuals with neurological and multiple musculoskeletal dysfunction. The primary focus is on rehabilitation skills including assessment, exercise, handling techniques, functional activities, equipment prescription, patient education, ADLs, as well as community mobility and governmental services. Laboratory. This course covers a number of topics, but includes material relative to the diagnosis and intervention for patients with neurological and musculoskeletal dysfunction.

512. Therapeutic Agents. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Theory and application of various hydrotherapy, phototherapy, and thermotherapy modalities in Physical Therapy, including heat, light, sound, and water. Laboratory.

513. Intervention Techniques II. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Theory and practical application of introductory patient care techniques in physical therapy including gait, range of motion, transferring, bandaging, wound care, vital signs, and aseptic and isolation techniques. Laboratory.

514. Case Management I. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Case management, with integration of examination, evaluation, diagnostic, plan of care, and intervention strategies. Verbal and written communication of results will be emphasized. In this course students work on case studies which include the entire case management of a patient, including examination, evaluation, diagnosis, prognosis and intervention.

519. Electrotherapy and Electrodiagnosis. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Theory and application of therapeutic electrical currents, biofeedback, electromyography, and nerve conduction velocity in physical therapy. Laboratory

520. Clinical Internship I. 18 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Full time clinical experience in selected physical therapy provider centers throughout the United States. This is a course which is 18 weeks long (two nine-week experiences at two different facilities) and includes full time clinical experience working with patients under the supervision of an experienced clinical faculty member.

521. Critical Inquiry I. 1 credit. Prerequisite: Registered in Professional Physical Therapy Curriculum. Introduction to the collection of clinical data leading to a case study report. Students write up two case studies regarding patients they have worked with. This includes examination, evaluation, diagnosis, prognosis and intervention and outcome.

522. Administration in Physical Therapy. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Lectures/discussion and seminar formats used to explore concepts of administration procedures as applied to Physical Therapy and the health care delivery system.

523. Lifespan I. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Course focus is on rehabilitation issues related to pediatrics including the characteristics of disabling conditions, developmental evaluation and intervention, the use of adaptive equipment, legal issues and strategies to promote collaborative service provision to children and families. Laboratory. Students learn the fundamentals of pediatric physical therapy which includes examination, evaluation, diagnosis and intervention.

524. Psychological Aspects of Disability. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Readings and discussion course. Study of psychological coping mechanisms, reactions and motivational factors pertinent to the disabled. Review of adjustment problems unique to specific disabilities and/or disease processes, including the terminally ill.

525. Clinical Examination and Evaluation II. 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Emphasizes patient/client management elements of examination and evaluation. Emphasis is given to systems review and differential diagnosis, clinical decision making resulting in referral and/or modified physical therapy interventions, and the communication of findings. Laboratory. This is a differential diagnosis course. Students learn learn clinical decision making skills, advanced examination/evaluation skills for all body systems. This is course is integral to manual therapy.

526. Manual Therapy II. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Fundamentals of spinal mobilization techniques along with theory and application of specific approaches to spinal manual therapy. Laboratory. This course covers spinal mobilization and manipulation techniques.

527. Critical Inquiry II. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Clinical research design, clinical decision making, and preparation of a case study and a paper on a clinical topic.

535. Lifespan II. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Examine the factors and forces that affect life quality in later years. The physiological, psychological, and sociological aspects of aging will be considered, including those influences in the cultural context that enhance and impede continued growth of the person. Laboratory. This course covers aspects of the geriatric population and would have some elements useful for diagnosis.

537. Strategies for Early Intervention. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. This course is designed to review current practices in early intervention. Course materials will focus on characteristics of disabling conditions that influence growth and development of motor skills, cognition and educational development. Emphasis will be on collaborative service provision with an interdisciplinary approach. Topics also covered include: current issues, assessment of the child/family unit and legislative guidelines for service provision. Elective course.

538. Advanced Pediatrics Assessment and Treatment Techniques. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. This course is designed to provide physical therapy students with opportunities to explore and implement standardized and criterion-referenced evaluation instruments to identify need areas for treatment. In addition, students will design treatment programs for children with disabilities by integrating current therapeutic techniques with efficacy studies. Elective course

539. Prevention and Wellness. 3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. The theory and practice of prevention of injury, maintenance and improvement of wellness, and sports-and work-related injury management with emphasis upon preparticipation screening, emergency/trauma evaluation, the role of support devices, and rehabilitation techniques appropriate for the athlete and employed. This course covers examination, evaluation and diagnosis of conditions with particular emphasis on sports medicine, work injury and health and wellness promotion.

549. Advanced Applied Anatomy/Clinical Kinesiology. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Study of applied anatomy and its importance to research and clinical application, particularly as related to Physical Therapy. Elective course.

552. Clinical Internship II. 18 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Full time clinical experience in selected physical therapy provider centers throughout the United States. This is another 18 week (two nine-week) full time clinical experience at two different clinical sites around the United States.

561. Seminar: Physical Therapy. 1-4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. This course serves to focus student attention toward graduate study in Physical Therapy. Explore and discuss areas of interest for student and faculty. May repeat to 4 credits maximum.

562. Readings: Physical Therapy. 1 to 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Review of current literature pertinent to Physical Therapy; critical examination of design, content, and validity of conclusions.

572. Teaching Experience in Physical Therapy. 1-3 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Supervised experience in University teaching in Physical Therapy. Projects in curriculum development, formulation of teaching/learning objectives, teaching materials, evaluation tools, and experience in competency based learning environment.

583. Critical Inquiry III. 1 credit. Registered in Professional Physical Therapy Curriculum. Introduction to research instruments including surveys, electrical and mechanical instrumentation critical to research methods. Includes discussion of validation, calibration and reliability of instruments used in physical therapy research. Students develop a proposal for their scholarly projects and complete IRB use of human subject forms.

590. Directed Studies/Clinical Concepts. 1-12 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Individualized study of a particular area of interest for the student approved by his/her major advisor and supervised by preceptors with specialty and/or recognized expertise in the area of interest. Study may include library research, clinical research, discussion/seminars, projects and directed clinical experience.

591. Critical Inquiry IV. 4 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Students begin data collection and analysis for the scholarly project requirement.

592. Case Management II. 2 credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Case management, with emphasis on the teaching/learning process and techniques targeted to promote and optimize physical therapy services. Strategies appropriate for instruction of patients/clients, health care providers, agencies, and the public will be addressed. This is advanced case management course which includes discussion patient care from the examination/evaluation stages to diagnosis/prognosis, intervention and outcome assessment.

990. Continuing Education Workshops in Physical Therapy. 1 to 8 Credits. Prerequisite: Registered in Professional Physical Therapy Curriculum. Credit in Physical Therapy may be granted for workshops, conferences, institutes, or other types of short-term activities, provided they have been approved for credit by the Chairperson of Physical Therapy and the Dean of the Graduate School. Written report of the activity is required. A one-week workshop shall carry no more than 1 semester hour of credit.

995. Scholarly Project. 1 credit. Prerequisite: Registered in Professional Physical Therapy Curriculum. Students provide a final written and oral report to the faculty on the results of their collaborative Scholarly Project.

996. Continuing Enrollment/Physical Therapy. Credit arranged.

DPT Required Program of Study (Student Enters Program with 90 credits and graduates with 216 credits, BS degree given at end of second semester). Each semester is 16 weeks, each summer session is 8 weeks.

Professional Year 01 – Fall Semester (17 cr.)
PT 401 .....Intervention Techniques I .....(2)
PT 402 .....Professional Communication and Behavior .....(2)
PT 409 .....Clinical Pathology I .....(4)
PT 422 .....Anatomy for Physical Therapy .....(5)
PT 423 .....Neuroscience for Physical Therapy .....(4)

Professional Year 01 - Spring Semester (19 cr.)
PT 410 .....Clinical Pathology II .....(3)
PT 412 .....Biomechanics and Kinesiology .....(4)
PT 413 .....Exercise in Health and Disease .....(3)
PT 415 .....Motor Control .....(3)
PT 417 .....Clinical Examination and Evaluation I .....(4)
PT 426 .....Manual Therapy I .....(2)

Professional Year 01 - Summer Session (10 cr.) – Graduate School
PT 512 .....Therapeutic Agents .....(3)
PT 513 .....Intervention Techniques II .....(3)
PT 514 .....Case Management I .....(2)
PT 519 .....Electrotherapy and Electrodiagnosis .....(2)

Professional Year 02 - Fall Semester (19 cr.) – Graduate School
PT 520 .....Clinic I: Clinical Practice .....(18)
PT 521 .....Critical Inquiry I .....(1)

Professional Year 02 - Spring Semester (17-18 cr.) – Graduate School
PT 522 .....Administration in Physical Therapy .....(3)
PT 523 .....Lifespan I .....(2)
PT 524 .....Psychological Aspects of Disability .....(2)
PT 526 .....Manual Therapy II .....(2)
PT 527 .....Critical Inquiry II .....(2)
PT 583 .....Critical Inquiry III .....(1)
EFR 515 .....Statistics I .....(3)
Electives .....(2-3)

Professional Year 02 - Summer Session (9-10 cr.) – Graduate School
PT 591 .....Critical Inquiry IV .....(4)
PT 592 .....Case Management II .....(2)
PT 562 .....Readings: Physical Therapy .....(1)
Electives .....(2-3)

Professional Year 03 - Fall Semester (16-17 cr.) – Graduate School
PT 511 .....Applied Movement Science/Rehabilitation Procedures .....(4)
PT 525 .....Clinical Examination and Evaluation II .....(4)
PT 539 .....Prevention and Wellness .....(3)
PT 535 .....Lifespan II .....(2)
PT 561 .....Seminar: Physical Therapy .....(1)
Electives .....(2-3)

Professional Year 03 - Spring Semester (19 cr.) – Graduate School
PT 552 .....Clinic II: Clinical Practice .....(18)
PT 995 .....Scholarly Project .....(1)

Note: The highlighted courses are courses that include basic science, pathology, examination and evaluation, differential diagnosis, treatment planning etc. The two Manual Therapy courses and Intervention I include mobilization/manipulation course content.

COMMUNIQUE

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The Supreme Court of Canada rejects the request for appeal presented by the Order of Chiropractors of Quebec
The rejection of the appeal by the highest court of the country confirms once and for all the ability of physiotherapists to practice vertebrate manipulation

Anjou, December 21, 2000 – Today, the Supreme Court of Canada has returned a verdict to reject the appeal presented by the Order of Chiropractors of Quebec against the decision of the Court of Appeal of Quebec. In its judgment rendered on February 25, the Court of Appeal of Quebec acquitted Philippe Thomas, physiotherapist, member of the Professional Order of Physiotherapists of Quebec, of the three main accusations "of illegal practice of chiropractic" for having conducted manipulation of vertebrates on two patients in 1987. The Order of Chiropractors of Quebec had decided to carry the verdict of the Court of Appeal before the Supreme Court of Canada.

" The decision of the Supreme Court confirms, once and for all, the right of competent physiotherapists to carry out the evaluation and the treatment using manual therapy (including mobilizations and manipulations) of problems related to the physical function of individuals whose backaches are a frequent symptom", emphasized Ms. Mariette L. Lanthier, president of the Professional Order of Physiotherapists of Quebec.

"For more that 50 years", she adds, "Physiotherapists have provided the public of Quebec services and health care of the highest universal quality. The announcement, today, only confirms what the population has recognized for a long time, that it can depend on competent physiotherapists to receive the most adequate health care, including manipulation of vertebrate when deemed necessary." As a healthcare professional recognized in the healthcare system of Quebec, the physiotherapist, with university training, must submit to strict rules of professional practice, according to the professional code.

Let us not forget that backaches, present in a high percentage of the population, including victims of work related and car accidents, are treated by physiotherapists on a daily basis. In Quebec, the majority of private and state insurance systems cover the costs related to physiotherapy treatment. This coverage gives the public access to the whole range of therapy that the physiotherapist can provide in his/her field of competence.

The mission of the Professional Order of Physiotherapists of Quebec is to insure the protection of the public by keeping watch over the practice of physiotherapy by its members and by contributing to their professional development. The nature and quality of services provided by physiotherapists must respond to the needs of the people and keep abreast of the evolution of the science and of physiotherapeutic practices.

For more information, please contact the Professional Order of Physiotherapists of Quebec at (514) 351-2770 or 1-800-361-2001.

Source: Professional Order of Physiotherapists of Quebec

Additional Information: Anne-Marie Laurin
BDDS Shandwick
(514) 393-1180

Training Generalist Physicians in Manual Therapy for Low Back Pain: Development of a Continuing Education Method

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Chapel Hill, NC

Abstract: *Recent national reports and guidelines support the value of manual therapy for acute mechanical low back pain. As part of a randomized trial of the management of acute low back pain, a training course in simple manual therapy was developed and implemented. The course, consisting of two sequential 1-day workshops, was developed for family physicians and internists with no prior training in manual therapy. Before and after the course, participants were surveyed on their attitudes and ability to manage low back pain. All participants (33) subsequently used manual therapy in their practices. Most were male (76%), Caucasian (88%), and 21% were in solo practice. Confidence in preparedness to manage low back pain rose from 15% to 70% and perceptions of having effective therapeutic skills rose from 39% to 58%. Busy clinicians can learn and implement simple manual therapy into their practices. The success of the course was built on structured learning with feedback on practical skills.*

The Journal of Continuing Education in the Health Professions, Volume 17, pp. 148-158. Printed in the U.S.A.

My presence here today is in response to Senate Bill Number 2349 and its attempt of chiropractors to limit the scope of practice of physical therapists. I represent myself as a physical therapist but also reflect the opinions and voices of physical therapists around the state. This bill, as amended, does not govern or limit my legally allowed scope of practice as a physical therapist and, therefore, upholds what is just and what is in our patients' best interests. If passed, it should be left amended as is.

In thinking about what this bill initially was trying to do, I remembered a time when I was younger when as kids we used to have people "crack our backs". Our friends used to grab us, bounce us up and down, even walk on our backs (believe me, I remember!). We even crack our own backs and necks from time to time. Is this illegal activity? No. Probably not wise, but not illegal. None of my friends were trained to walk on my back. None were educated in spinal mechanics. But as physical therapists, we are trained and educated. All graduating physical therapists have had hours and hours of biomechanical training along with additional hours of hands on experience as interns with supervision of clinical experts. This level of education has provided proficiency in manipulation techniques for the spine. Currently many schools are now educating their students to the level of Doctorate degrees including UND and University of Mary. (I graduated in 1991 with a Bachelor's degree from out of state!) Yet, even with the dramatic increase in entry level education, outside entities are still trying to limit our practice of manipulation. (This type of procedure has not had a single legal problem associated with it in the state of North Dakota.) One can deduce, therefore, that without a history of any problems and with increased levels of entry level education, new graduates are much better prepared than in the past. Yet manipulation is one of the many modalities in my practice. I use it frequently and could not image a successful practice without it. Why? Because it is effective. A passive, skilled movement to the spine (manipulation) when indicated is a very useful rehabilitative tool. It makes people feel better. It restores function, and that is the focus of my job: to improve people's lifestyle. Could anyone imagine having a shoulder surgery, knee surgery, or hip fracture repair, without needing to stretch (manipulate) it afterwards for healing purposes? No. It would, in fact, be unprofessional and neglectful. Motion must be restored to improve function and, therefore, lifestyle. The spine is NO DIFFERENT. It must be mobile, and physical therapists, with their knowledge of bones, muscles, and joints, can do it safely, effectively, and cost efficiently.

Jeff Schmidt PT, MTC, EMT-B

Jeff Schmidt, PT, MTC, EMT-B

To: Representatives of the House Human Services Committee

Re: SB 2349

From: Kevin Axtman PT LATC, member of the North Dakota State Examining Committee for Physical Therapists

Dear Representatives of the House Human Services Committee,

I am here today to speak on SB 2349. The bill before us today was originally drafted to exclude any professional from doing manipulation to the spine unless certain educational requirements and clinical training was met as set up by the chiropractors. This was clearly an attempt to modify the scope of practice of physical therapists. After debate in the Senate committee, it was amended (Jack McDonald's amendment) to restrict its provisions to chiropractors. There are several reasons why this bill should remain in its amended form or be given a do not pass label;

- We do not need chiropractors regulating other health care professionals! The North Dakota State Examining Committee for Physical Therapists regulates the physical therapists and physical therapy assistants in the state through its Practice Act and Rules and Regulations. The committee consists of three physical therapists, two physicians, and a consumer member all appointed to staggered five year terms by the governor.

- Physical Therapists have been educated and trained in mobilization/manipulation techniques for the extremities and spine, and it has been included in their scope of practice. Physical Therapists also have continuing education requirements which must be met every two years in order to maintain licensure in the state of North Dakota. Audits of continuing education requirements are performed yearly by the North Dakota State Examining Committee for Physical Therapists.

- The North Dakota State Examining Committee for Physical Therapists has received no complaints from the public in which manipulation was improperly or adversely performed to the spine. This has not been a safety issue for the committee!

- Many treatment techniques utilized by physical therapists and chiropractors are the same; modalities such as ultrasound and electrical stimulation, exercise and mobilization/manipulation. Mobilization/manipulation is not exclusive to the chiropractic profession! Physical Therapists and chiropractors are allowed to perform these activities within the limits of their own scope of practice.

- "Manual therapy techniques (including mobilization/manipulation, lymphatic drainage, manual traction)" is coded for reimbursement for physical therapists in the American Medical Association (AMA) Common Procedural Terminology (CPT).

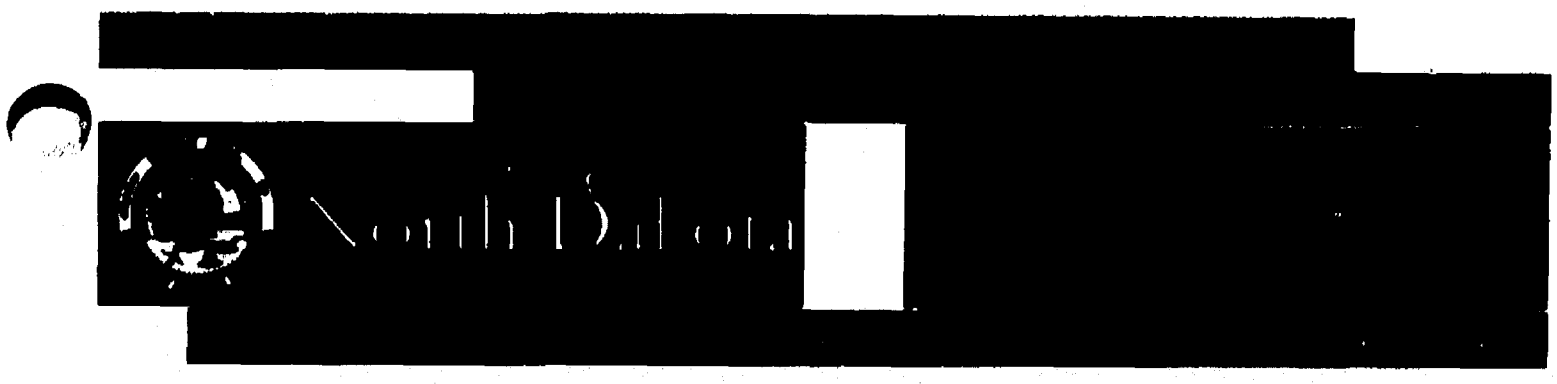
Adam Burke

BSC Student

I would like to make two points.

First: I am attending BSC full time, this being my sixth semester, finishing up my prerequisite program for chiropractic school. Next semester I will begin at North Western Health and Sciences University under their chiropractic program. When I am a licensed chiropractor I will have approximately eight years of my life invested into the study the human body focusing on the effects and techniques of spinal manipulation. I feel that to begin to comprehend the effects and techniques of spinal manipulation this amount of study is not only necessary, but mandatory. I feel that attending a few seminars on spinal manipulation, even with a strong anatomical and physiological background, does not qualify you for spinal manipulation, **and in fact letting a person practice spinal manipulation without attaining a set of mandatory classroom and hands on study time cheapens the idea of chiropractic care.**

Second: Putting chiropractors and physical therapists aside, the issue at hand is the care of the patient, **I think it is obvious that the higher the standard is set for spinal manipulation the more safety is offered to the patient. This safety and security the patient is obligated to.**



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Physical Therapists, State Examining Committee For

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The Board licenses physical therapists and physical therap
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