chapter two

The Application of Wellness to Physical Therapy

The concept of total wellness recognizes that our every thought, word, and behavior affects our greater health and well-being.

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OBJECTIVES

Upon the completion of this chapter, you should be able to:

1. Define the disciplines that contribute to and impact wellness.
2. Differentiate between the credentials of wellness practitioners and medical professionals.
3. Differentiate between medical providers with and without an expertise in wellness.
4. Differentiate between the terms *restorative physical therapy*, *maintenance physical therapy*, *prevention physical therapy*, and *wellness physical therapy*.
5. Discuss the issues of standards of care and malpractice as they relate to the practice of wellness by physical therapists.
6. Identify why physical therapists need to possess an operational knowledge of wellness.
7. Discuss the entry-level physical therapy accreditation requirements related to wellness.

8. Describe how a patient's wellness can affect her or his health and ability to engage in and benefit from physical therapy.
9. Explore how physical therapists answer patients' questions about wellness.
10. Discuss physical therapists as wellness role models.

SECTION 1: WELLNESS PRACTITIONERS

Disciplines That Contribute To and Impact Wellness

Many disciplines contribute to public wellness and health promotion. Medical disciplines that contribute to wellness include, but are not limited to, athletic trainers, chiropractors, dentists, dieticians, exercise physiologists, healthcare administrators, medical physicians, mental health counselors, nurses, occupational therapists, physical therapists, podiatrists, psychologists, recreation therapists, social workers, and speech and language pathologists. Scientists who contribute to wellness include, but are not limited to, biologists, chemists, epidemiologists, and statisticians. Other disciplines that contribute to wellness include, but are not limited to, accountants, architects, economists, educators, entrepreneurs, financial planners, insurance personnel, managers, marketing personnel, and politicians. Obviously, a wide array of disciplines contribute to and impact wellness, and physical therapy is only one of these disciplines.

Credentials

Generally speaking, the hierarchy of credentials from most to least prestigious is licensure, registration, and certification. Unregulated practice is not on this list at all. When the physical therapy profession was initially established in the early 20th century, it was unregulated. During World War I, certification was established. Some years thereafter, physical therapists were required by most states to be registered. Eventually, everyone in the physical therapy profession was required to be state licensed.

Credentials and accreditation of medical and healthcare practitioners varies from discipline to discipline and from state to state. For example, every U.S. state requires medical doctors and physical therapists to be licensed, but not all of them require occupational therapists and athletic trainers to be licensed. Only a few states require a massage therapist to be licensed and only Louisiana requires an exercise physiologist to be licensed (Salzman, 2001a). Additionally, while occupational therapists must be registered in all states, physical therapist assistants must be licensed in certain states and registered or certified in others; they are completely unregulated in still others (APTA, 2008c).

Credentials of medical and healthcare practitioners are often linked to their educational requirements. Physical therapy programs, occupational therapy programs, and medical programs each must be accredited by a specific entity. These include the Commission on the Accreditation of Physical Therapy Education (CAPTE), the Accreditation Commission of Occupational Therapy Education (ACOTE), and the American Medical Association (AMA), respectively. A more generalized accreditation entity, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) certifies many other healthcare educational programs (Salzman, 2001b). Not surprisingly, it is generally accepted that the AMA, CAPTE, and the ACOTE are more prestigious than the CAAHEP accreditation.

Unlike all other medical and healthcare practitioners, with the notable exception of exercise physiologists, there is no regulation of wellness practitioners. There are no minimal educational requirements and no state license or registration is needed by anyone providing wellness services. While several organizations offer a certification in the fitness aspect of wellness (e.g., APTA and the American College of Sport Medicine [ACSM]), proof of education or certification in wellness is not required for someone to offer wellness programs.

Provider Expertise

A physical therapy clinic employs physical therapists and support personnel (e.g., physical therapist assistants, aides, office employees) to provide *restorative* (i.e., medically indicated) physical therapy to patients. Only those providers with the appropriate expertise should provide skilled services. While it should be obvious that an aide does not possess the expertise of a physical therapist, it is worthwhile to note that most insurance companies do not recognize or differentiate between the expertise of an athletic trainer, exercise physiologist, and many other healthcare providers. The bottom line is that most insurance companies place these healthcare providers in the same category as aides and do not reimburse for their services.

In contrast to a physical therapy clinic, a wellness clinic does not provide medically indicated physical therapy services. Instead, a wellness clinic provides wellness therapy. In some cases, a wellness facility also may provide prevention and/or maintenance services. Typically, wellness clinics do not employ physical therapists but instead employ healthcare providers whose salary requirements are less than that of a physical therapist. These providers include an athletic trainer, exercise physiologist, or a so-called "fitness trainer." While athletic trainers are well educated and licensed in an increasing number of states, and exercise physiologists are well educated and licensed in Louisiana, "fitness trainers" may or may not have completed a series of courses or specific education in fitness and wellness, and may not even be certified.

Summary: Wellness Practitioners

Physical therapy is just one among a wide variety of medical professional and nonmedical practitioner disciplines that contribute to and impact the wellness of others. Unlike physical therapists, wellness practitioners are unregulated and usually not certified. Physical therapy clinics employ physical therapists and similar medical professionals as well as support personnel to provide restorative therapy to patients; wellness clinics tend to provide nonmedically indicated therapy.

SECTION 2: PHYSICAL THERAPY SERVICES: RESTORATIVE, MAINTENANCE, PREVENTION, AND WELLNESS

While in many (if not most) cases physical therapists provide restorative physical therapy, they also provide maintenance physical therapy. There is increasing evidence that they are providing preventative and wellness physical therapy. Accordingly, physical therapists must understand the difference between restorative, maintenance, prevention, and wellness physical therapy. Independent of the type of physical therapy a physical therapist provides, she or he must maintain high standards of care and not commit malpractice.

Although the APTA (2001b) states that individuals receiving physical therapy may be referred to as a "patient" or as a "client," I believe that it is more appropriate to define an individual as a *patient* if she or he is receiving restorative physical therapy and as a *client* if she or he is receiving wellness services. I do not condone the label of "customer" under any circumstances, even if the individual is purchasing a physical therapy or wellness product from a physical therapist or a physical therapy clinic.

Restorative Physical Therapy

Restorative physical therapy is also referred to as *medically indicated*, *skilled*, or *traditional therapy*. To be medically indicated, physical therapy must be 1) necessary; that is, there must have been a change in condition that warrants a new episode of care; 2) reasonable in terms of frequency, duration, and type; 3) anticipated to provide significant benefit, especially in terms of functional gains; and 4) provided by an individual with the appropriate credentials, such as a physical therapist or in some cases a physical therapist assistant (Miller, 2002).

Restorative therapy is typically provided to clients in a rehabilitative setting, such as a medical center, skilled nursing home, or outpatient center. It also can be provided in the patient's home (also termed *home health*). Restorative physical therapy often is provided one-on-one; however, group therapy is an option for patients who present with a similar diagnosis. Typically, restorative physical therapy is largely, if not totally, reimbursed by a third-party payer, which most likely is the patient's health insurance company.

Maintenance Physical Therapy

The primary goal of *maintenance* physical therapy is to maintain the current level of function and/or other medical status (e.g., safe blood pressure levels). In contrast to restorative therapy, it is not medically indicated. Specifically, there is no change in condition that warrants restorative physical therapy and/or it is not anticipated that the patient/client will obtain a significant benefit from this therapy. In fact, the patient's function and/or other medical status may decline secondary to disease progression and/or advancing age over the course of the maintenance therapy. The instructor of a maintenance session may require an expertise but not necessarily the knowledge of a physical therapist. An example of maintenance therapy is a walking exercise program for residents in a skilled nursing facility.

Maintenance therapy typically is provided to patients/clients by a sponsoring organization, such as a skilled nursing facility or an assisted living facility. The sponsoring organization may provide the maintenance free of charge or charge a fee to participants. Maintenance therapy can be provided to a group of clients or to an individual. One example is a physical therapist who provided maintenance therapy to a gentleman who had chronic functional deficits secondary to a cerebral vascular accident (stroke) sustained years earlier. Both the physical therapist and the patient recognized that the therapist's interventions would not enhance the patient's function, but they were successful in delaying his decline in function. This physical therapist had been providing maintenance to the patient twice per week for well over 5 years and the client was happy to self-pay for the therapy.

Prevention Physical Therapy

Prevention physical therapy is provided to clients to avoid or delay onset of a disease (primary prevention), provide an early diagnosis and prompt intervention to at-risk clients (secondary prevention), and provide interventions to prevent a regression of a chronic or irreversible condition (APTA, 2001b). Like maintenance therapy, it is not anticipated that clients will obtain significant functional benefit from prevention therapy. However, it can enhance a client's function and quality of life. Prevention physical therapy is often sponsored by an organization, such as a health club, a company, or a skilled nursing facility. It also can be offered by an agency such as a county health department. Prevention therapy is not typically reimbursed by insurance companies but may be provided free of charge to participants.

Wellness Physical Therapy

The primary goal of *wellness* physical therapy is to maintain or enhance the wellness practices of an individual or group. Wellness practices can be related to the physical, mental, and/or social domains.

In contrast to restorative therapy, it is not medically indicated. Specifically, there has been no change in condition that warrants restorative physical therapy. Wellness therapy will enhance one or more aspects of a client's overall wellness (e.g., aerobic capacity wellness or mental wellness). While the client may derive much benefit from the wellness therapy (e.g., a woman reducing her body fat from 35% to 28%), the benefit is not considered significant in the medical community.

The instructor of a wellness session may require expertise but not necessarily the depth of knowledge of a physical therapist. An example of wellness therapy is an exercise and nutrition program to reduce body fat. (Note: If the client is obese, this type of therapy might be considered restorative. However, if the client is simply over-fat, and there is no medical/rehab diagnosis; it can be defined as wellness therapy, if not also prevention therapy.)

Wellness therapy is typically provided to clients by a sponsoring organization such as a company or health club. The sponsoring organization may provide the wellness free of charge or charge a fee. Wellness therapy can be provided to a group of clients (e.g., a healthy cooking class at a wellness center) or to an individual (e.g., personal training). Typically, wellness therapy is not reimbursed by insurance companies.

I have been hired by organizations and individual people to provide wellness services. Examples of these wellness services include, but are not limited to develop a wellness program for the employees of the Sheppard Pratt Medical Center (Baltimore, Maryland); present a private seminar about fitness and body composition wellness to small groups; present an 8-hour wellness seminar to Kaiser Permanente physical therapists; assess and provide recommendations to single individuals or those in small groups.

Standards of Care and Malpractice

Standards of care can be defined as the "ways and means by which services should be delivered to give reasonable assurance that desired outcomes will be achieved in a safe manner" (ACSM, 2000, p. 264). Organizations that influence the standards of care of medical and healthcare practitioners include federal and state statutes (e.g., Medicare

statutes and state practice legislations), professional organizations (e.g., the APTA and the ACSM), third-party payers (e.g., Medicare as well as the policies of other insurance companies, such as Blue Cross and Blue Shield), and medical corporations and agencies (e.g., the rehabilitation company for which you might be employed). It is important that you examine the physical therapy practice legislation and related statutes of the state in which you seek employment as a physical therapist. It is also important that before you accept employment, you ascertain and consider the standards of care of the prospective employer to ensure that they are compatible with your personal convictions.

If an individual is *negligent*, defined as one who fails to comply with a standard of care, that individual has engaged in a type of civil wrong called a *tort*. Negligence acts by a medical provider is specifically referred to as *malpractice*. Because physical therapists are licensed medical professionals, any act of negligence is malpractice. Because wellness practitioners are unregulated, acts of negligence are not considered malpractice. However, if a physical therapist or another medical practitioner provides wellness services, she or he can be liable for malpractice secondary to his or her credentials as a physical therapist. In addition, the physical therapist's licensure may be jeopardized.

Summary: Physical Therapy Services

Physical therapists provide four different types of therapeutic services: restorative, maintenance, preventative, and wellness. Restorative physical therapy is the traditional type of therapy and is known also as medically-indicated therapy. Maintenance physical therapy, prevention physical therapy, and wellness physical therapy are not medically indicated but nonetheless may provide much benefit to the participants. While restorative therapy is generally reimbursed by a patient's insurance company, the other types of therapy are not.

Standards of care define how skilled therapy should be provided. A physical therapist practicing wellness may be sued for malpractice and/or be subject to licensure infractions.

SECTION 3: PHYSICAL THERAPY EDUCATION

Students in physical therapy programs should endeavor to possess an operational knowledge of wellness because *A Normative Model of Physical Therapist Professional Education* has required entry-level students to be educated in wellness since 2001. *A Normative Model of Physical Therapist Professional Education* is published periodically by the Commission on the Accreditation of Physical Therapy Programs (CAPTE), an affiliate of the American Physical Therapy Association. The version used by entry-level physical therapy programs until 2004 was the *Normative Model of Physical Therapist Professional Education: Version 2000*, including the *Supplement to a Normative Model of Physical Therapist Professional Education: Version 2000*, which consisted of information related to wellness. *A Normative Model of Physical Therapist Professional Education: Version 2004* became effective in June 2004 (publications representative for the APTA; personal communication; August 24, 2004).

A Supplement to a Normative Model of Physical Therapist Professional Education: Version 2000 contained three sections related to wellness: exercise science, exercise physiology, and nutrition. In the 2004 version, the exercise science section was expanded and the exercise physiology and nutrition sections were combined, but enhanced. The 2004

version also introduced two new wellness sections: 1) a practice management section dedicated to prevention, fitness, health promotion, and wellness, and 2) a section related to wellness in the Foundational Sciences Matrix.

The exercise science content within *A Normative Model of Physical Therapist Professional Education: Version 2004* is verbatim to the exercise science content in the *Supplement to a Normative Model of Physical Therapist Professional Education: Version 2000*. The exercise science content continued to consist of exercise prescription, implementation, and modeling of strength training; power training; aerobic and anaerobic conditioning; coordination, agility, and balance; and stress management and relaxation. In *A Normative Model of Physical Therapist Professional Education: Version 2004*, the terminal and instructional objectives for exercise science content requires students to be able to analyze and implement programs to enhance strength, aerobic capacity, flexibility, relaxation, and balance and coordination.

The exercise physiology content identified in *A Supplement to a Normative Model of Physical Therapist Professional Education: Version 2000* included the thermoregulatory system, including effects of the environment; skeletal muscle cell anatomy and physiology, including fiber types and cellular changes and fiber type adaptations in response to exercise; adipocyte anatomy and physiology, including changes with diet and exercise, and cardiac muscle adaptations. The sole terminal objective related to exercise physiology was to "discuss mechanisms to exercise an individual to their maximum capacity" (p. 6). Compared to the exercise physiology information presented in the 2000 supplement, the exercise physiology content in the 2004 version was significantly enhanced. For example, there are behavioral and terminal objectives related to neuromuscular, musculoskeletal, and cardiopulmonary responses during progressive exercise; the principles of exercise testing and prescription; and the assessment and analysis of body composition.

The definition of wellness provided in *The Normative Model of Physical Therapist Professional Education: Version 2004* is "[a]n active process of becoming aware of and making choices toward a more successful existence" (p. 69). Educational outcomes related to wellness in the 2004 version include assessment and screenings, referrals, evidenced-based interventions, patient education, patient compliance, and reevaluation. Expectations related to prevention, fitness, health promotion, and wellness in the 2004 version are

> Provide culturally competent physical therapy services for prevention, health promotion, fitness and wellness to individuals, groups, and communities;
>
> Promote health and quality of life by providing information on health promotion, fitness, wellness, disease, impairment, functional limitation, disability, and health risks related to age, gender, culture, and lifestyle within the scope of physical therapist practice;
>
> Apply principles of prevention [health promotion, fitness, and wellness] to specific populations. (pp. 63–64)

Unlike its earlier editions, *The Normative Model of Physical Therapist Professional Education: Version 2004* includes an entire practice management section dedicated to prevention, fitness, health promotion, and wellness. Within this section is the Health Promotion, Fitness, and Wellness Matrix that includes the primary content areas and examples of terminal objectives and instructional objectives related to those content areas. The Prevention, Health Promotion, Fitness, and Wellness Matrix consists of four content areas: "Foundational and

clinical sciences; Cost-benefit analysis; Community information health and wellness; public-sector and private sector resources . . . ; [and] prevention, health promotion, fitness and wellness programs" (p. 80).

A Normative Model of Physical Therapist Professional Education: Version 2004 also discusses wellness in the Foundational Sciences Matrix. In this section, wellness theories and models, including the change model, are discussed. Sample terminal objectives related to wellness theories and models are expansive. For example, a sample terminal objective is to "promote health, exercise, fitness, and wellness to all populations, including those with a disease or condition that may lead to impairments, functional limitations, or disabilities" (p. 101). The sample instructional objectives also require clinical expertise. For example, a sample instructional objective is related to developing strategies to address modifiable cardiac risk factors.

A Normative Model of Physical Therapist Professional Education: Version 2004 also includes content related to psychological, social, ethical, and intellectual wellness; however, it does not overtly identify these as being related to the wellness. In the psychosocial realm, the 2004 version identifies the awareness of self and others, teamwork and group dynamics, cultural competence, health behavior change theories and models, emotional and psychological responses to functional limitations and diseases, physical and emotional abuse, faith and religion, sexuality, and holistic health. In the social realm, the 2004 version identifies professional roles and recognition, the sociology of health professions, and professional organizations. In the ethical realm, it identifies patient rights, values education, the role of virtue in the profession, and advocacy. In the intellectual realm, it identifies teaching methods and learning theory. Within the management sciences content, it identifies time management. Effective time management is directly related to wellness because it is linked to stress management and psychological wellness.

Physical therapists who possess an enhanced understanding of wellness may find that their ability to provide restorative therapy is improved. Of the various dimensions of wellness, physical therapists are likely to possess a basic competence in fitness and nutritional wellness, because these aspects apply best to the needs of most patients/clients. (The ability to engage in and benefit from physical therapy is discussed in Section 4 in this chapter.) Competence in applicable aspects of psychological wellness will benefit the physical therapist when she or he addresses patient compliance, both in the clinical setting as well as in terms of a patient's home exercise program. (Mental wellness is discussed in Chapter 8.) Physical therapists who possess a competence, if not an expertise, in wellness also may find that their marketability is greater. Those who did not explore wellness in their entry-level curriculum and/or in post-professional seminars or courses should endeavor to obtain at least a basic competence knowledge of wellness.

Summary: Physical Therapy Education

A Normative Model of Physical Therapist Professional Education: Version 2004, which is utilized in the accreditation of entry-level physical therapy curriculums, includes numerous sections related to wellness. Some of these sections utilize the term *wellness* and other sections do not. In comparison to its earlier versions, the wellness requirements in

the 2004 version are significantly expanded. Physical therapists who did not explore wellness in their entry-level curriculum should gain a competence in wellness so they can enhance their marketability and improve patient/client care.

SECTION 4: WHY SHOULD PHYSICAL THERAPISTS POSSESS AN OPERATIONAL KNOWLEDGE OF WELLNESS?

Wellness is important in the provision of physical therapy. Wellness directly affects the patient's/client's health, which in turn can decrease her or his ability to engage in and benefit from physical therapy. Impaired wellness also can negatively impact those with chronic condition. Stuifbergen, Becker, Blozis, Timmerman, & Kullberg (2003) found that a wellness intervention improved health-promoting behaviors, self-efficacy for health behaviors, mental health scales, and pain scales in women with multiple sclerosis. In addition, decreased body composition wellness negatively impacts the exercise capacity of those with type 2 diabetes (Ribisl et al., 2007) and also negatively impacts those with osteoporosis (Zhao et al., 2007).

Independent of a patient's physical health and medical (including physical therapy) diagnoses, a patient's wellness affects her or his ability to engage in and benefit from physical therapy. For example, if a patient's aerobic capacity wellness is poor and/or she or he presents with a comorbidity (i.e., in addition to her or his primary diagnosis), she or he may only be able to tolerate a more conservative treatment plan. Patients who are only able to engage in a conservative treatment plan may require an extended duration of rehabilitation and/or not be able to achieve the maximum benefits from the physical therapy program.

Because wellness is global and pervasive in scope, it is likely that most if not all of your patients/clients will present with an impaired level of wellness. In fact, in many cases, a particular patient/client will present with a deficiency in more than one dimension of wellness. For example, one patient may present with deficiencies in the financial, family, and environmental dimensions of wellness; another patient may present with deficiencies in psychological, fitness, and nutritional dimensions of wellness. While it is beyond the scope of a physical therapist to comprehensively address all types of wellness deficiencies, we should perform a wellness systems review (similar to that described in the *Guide to Physical Therapist Practice* [APTA, 2001b]) for each (restorative) patient and refer her or him to appropriate professionals as indicated. Further, we should examine, evaluate, diagnose, define prognoses, and treat those dimensions of wellness that are medically indicated and within our scope of expertise.

If a patient is deficient in one or more dimensions of wellness, her or his ability to engage in and/or benefit from physical therapy may be impaired. For example, I once provided physical therapy to an 80-year-old female patient who was anorexic. She weighed about 80 pounds. She did not eat an appropriate amount of calories, protein, and carbohydrates; her consumption of certain vitamins and minerals was also deficient. The patient presented with muscular weakness and atrophy, the physician's order was for strengthening. It would not have been appropriate for me to engage the patient in strength training exercises until her nutritional intake was properly addressed. Forcing her to engage in strengthening exercises without first having her diet improved might have caused her body to engage in an unhealthy even life-threatening level of muscle degradation for gluconeogenesis.

Another example is financial wellness. Certainly, if a patient is financially impoverished, her or his ability to engage in physical therapy can be significantly impaired if not prohibited. A further example involves mental wellness. A patient's mental wellness, including but not limited to interest in the rehabilitation process, awareness, and importance of self-selected functional goals, self-image, and motivation can significantly affect a patient's ability and willingness to engage in and indeed benefit from physical therapy.

Patient Questions Related to Wellness

Patients and clients ask physical therapists all kinds of questions related to their wellness. We should provide advice that is evidence based rather than only anecdotal data. People tend to respect information provided by physical therapist because we are credentialed medical professionals. Many are perhaps more likely to query those of us who possess a doctorate.

Physical therapists should possess a basic knowledge of those dimensions of wellness that their patients/clients are likely to present. Perhaps more importantly, physical therapists should possess the ability and willingness to critically analyze the published wellness information to ensure that it is valid before applying it to the therapeutic realm or sharing it with their patient. As with other types of physical therapy, wellness therapy always should be evidence based.

If a physical therapist does not possess the knowledge to appropriately answer a patient's question, a personal opinion and/or anecdotal information should not be offered because it may be flawed. Erroneous advice may give the patient false hope and possibly cause the patient harm. If the question is outside of the professional scope, the physical therapist should advise the patient to consult with another medical professional. In certain cases, it may be appropriate for the physical therapist to seek out additional information and then decide if she or he should answer the patient's question or refer the patient to an appropriate specialist.

Physical Therapists Are Wellness Role Models

Diverse nonphysical therapy medical professionals, including physicians (Hash, 2002), nurses (Fuimano, 2004; Pierson, 2000; Resnick, Magaziner, Orwig, & Zimmerman, 2002; Somerset-Butler, 2004), psychologists (McLoughlin & Kubick, 2004), and counselors (Myers, Mobley, & Booth, 2003), recognize and support their status as wellness role models. Of all of the medical disciplines, nursing appears to most strongly embrace their function as role models. According to Fenton (2004), nurses need to be role models to each other and to other health professional colleagues. Nursing practitioners have even hypothesized that positive role modeling can enhance patient compliance (Resnick et al., 2002). A succinct definition of a role model is one who is "walking the talk" (Yancey et al., 2004). A more detailed description of the concept is provided by Fuimano:

> Being a model means that you consciously decide to act in a way that others will want to emulate. . . . [It] demonstrates a commitment to yourself and others as you "walk your talk" . . . . It means you care about yourself and how you present yourself to the world. . . . It says that you take yourself . . . seriously. Modeling for others doesn't mean that you

> expect others to be like you; you can only model your personal best. But when you model a way of being; others can learn to adopt those qualities they find most . . . (2004, p. 16)

Like all other medical providers, physical therapists are wellness role models. Until recently, however, there has been little affirmation of this position in the literature. Preliminary studies of the wellness of physical therapy students suggested that physical therapists do and should serve as wellness role models (Fair, 2003, 2004b). In an article published in the *Magazine of Physical Therapy*, Landry (2004) discussed the role of physical therapists as wellness role models. However, because the APTA's (2001b) *Guide to Physical Therapist Practice* and *A Normative Model of Physical Therapist Professional Education: Version 2004* emphasize the physical fitness aspects of wellness, physical therapists should focus their attention on themselves as fitness wellness role models. In my own study comparing the aerobic capacity wellness of a group of female and male physical therapist members of the APTA, I concluded that "[Physical therapists] PTs should prioritize fitness self-wellness and role model fitness wellness. Similar to other [medical] professionals, the APTA should advocate that PTs [physical therapists] lead by example in the area of fitness wellness" (Fair, 2007, p. 10).

Even if a physical therapist is capable of properly educating a patient/client about a specific wellness issue, the patient/client may consciously or unconsciously model the therapist's behaviors even if these actions contradict that wellness education. A hypothetical (yet all too often actual) case is the medical doctor who smokes cigarettes but tells his patients that they should not smoke. Another example is the parent who consumes great quantities of alcohol and demands that the children not imbibe. How much credibility do you demonstrate if you tell your patients/clients that they should or should not do something to be well, and you are a poor wellness role model?

Despite our value as wellness role models, particularly fitness wellness role models, there is no evidence that physical therapists actually are well in terms of their fitness wellness. In fact, my own research suggests that physical therapists are deficient in fitness wellness and mirror the typical American rather than other groups of medical professionals (Fair, 2005, 2007).

Summary: Why Should Physical Therapists Possess an Operational Knowledge of Wellness?

Physical therapists must possess an operational knowledge of wellness because a patient's/client's wellness directly affects her or his health as well as the ability to engage in and benefit from physical therapy. Because wellness is global in nature, many of our patients/clients will present with an impaired level of wellness. While it is beyond the scope of a physical therapist to comprehensively address all types of wellness deficiencies, we should perform a wellness systems review of each (restorative) patient and, as indicated, make referrals to appropriate professionals. Further, we should examine, evaluate, diagnose, define prognostics, and treat those dimensions of wellness that are medically indicated and within our expertise.

Patients ask physical therapists about wellness. Patients assume that physical therapists are experts about all aspects of wellness and trust their opinions. Physical therapists should provide evidence-based information rather than anecdotal advice, and refer questions that are outside of their expertise to an appropriate practitioner. Physical therapists should not provide information that may mislead or cause harm to the patient.

A succinct definition of a role model is one who is "walking the talk" (Yancey et al., 2004). Many medical professionals do embrace their value as wellness role models. Like all other medical practitioners, physical therapists are wellness role models (Fair, 2004b; Landry, 2004). Patients and clients model the behaviors of their physical therapist even if the therapist's actions contradict the wellness advice provided.