



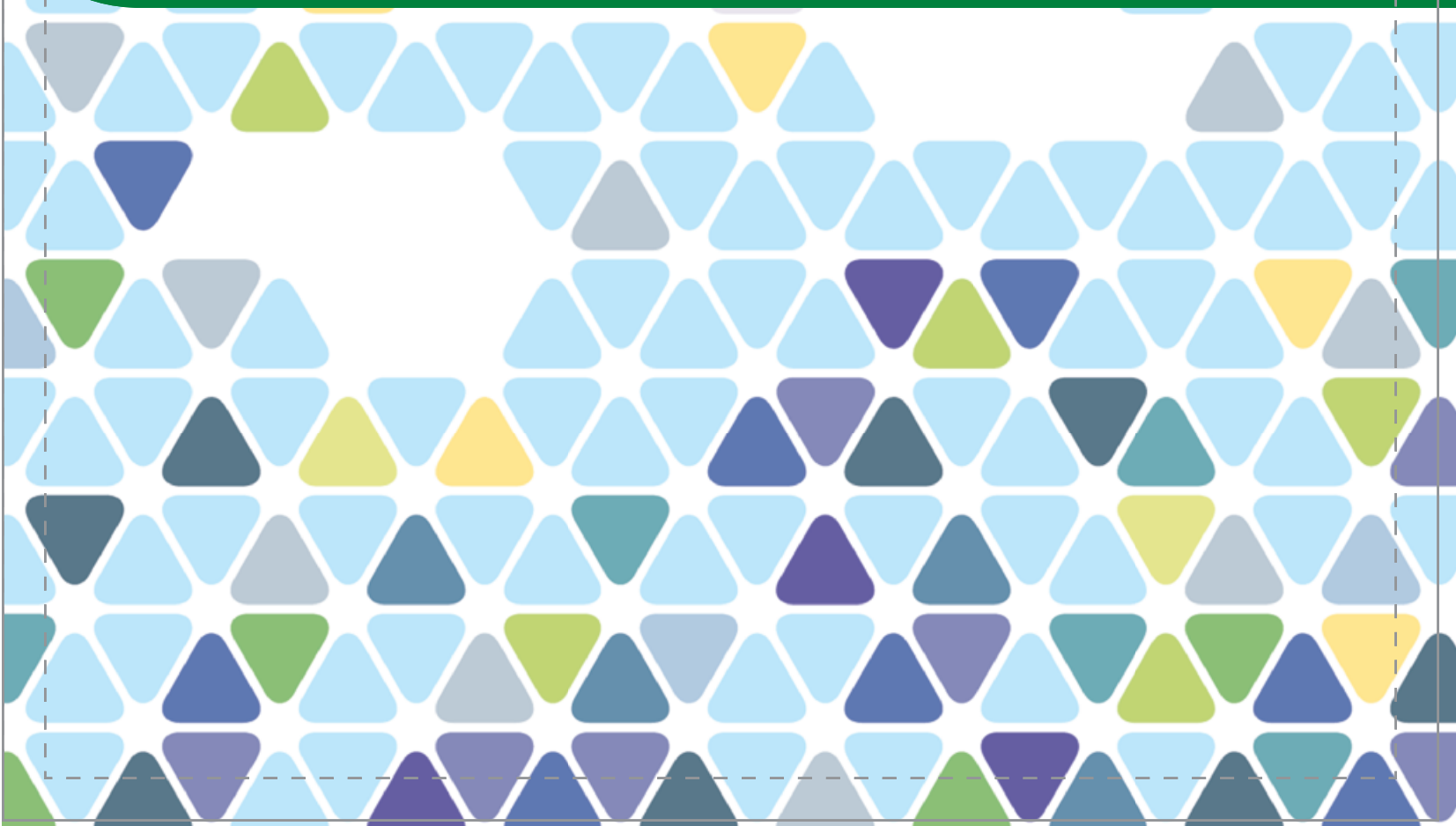
## PART I

# The Profession of Physical Therapy

This part is divided into three chapters:

- CHAPTER 1: Development of the Physical Therapy Profession
- CHAPTER 2: The Physical Therapist Assistant as a Member of the Health Care Team
- CHAPTER 3: Physical Therapy Clinical Practice

In these three chapters, we will discuss the history of rehabilitation treatments including therapeutic exercises, and the organization, history, values, and culture of the profession of physical therapy. We will also explore the differences in role, function, and supervisory relationship of the physical therapist (PT), the physical therapist assistant (PTA), and other health care practitioners and ancillary personnel.





# CHAPTER 1



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## Development of the Physical Therapy Profession

### OBJECTIVES

After studying this chapter, the reader will be able to:

1. Discuss the history of rehabilitation treatments (including therapeutic exercises) from ancient times through the 1900s.
2. Describe the history of the physical therapy profession and its five cycles of growth and development.
3. Identify the values and culture of the physical therapy profession.
4. Describe the APTA's mission and its goals in regard to PTs and PTAs.
5. Explain the organizational structure of the APTA.
6. Discuss the benefits of belonging to a professional organization.
7. Name the other organizations involved in the physical therapy profession.

### KEY TERMS

American Physical Therapy Association (APTA)  
Commission on Accreditation in Physical Therapy  
Education (CAPTE)

disability  
functional limitations

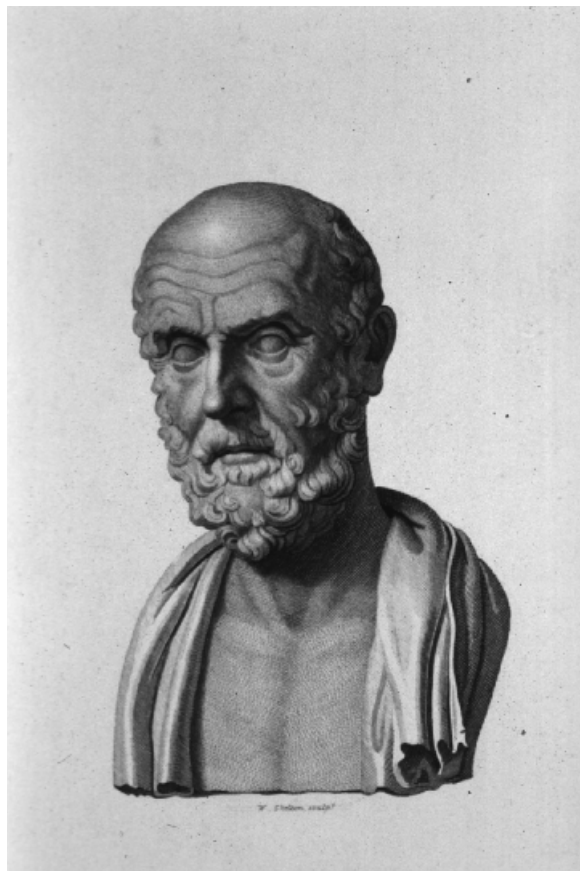
### History of Rehabilitation Treatments Including Therapeutic Exercises

It may be difficult to believe that some types of treatments utilized in physical therapy today, such as therapeutic massage, hydrotherapy (water therapy), and therapeutic exercises, were used in antiquity—around 3000 BC by the Chinese and around 400 BC by the Greeks and Romans. Therapeutic exercise and massage with aromatic oils were

probably the first therapeutic modalities applied by the Greeks and Romans in a purposeful way to cure health problems. Written and pictorial records from the ancient civilizations of China, Japan, India, Greece, and Rome also contain descriptions and depiction of massage and exercise. Researchers have found evidence that the application of heat, cold, water, exercise, massage, and sunlight was often used to abate physical afflictions even during prehistoric times.

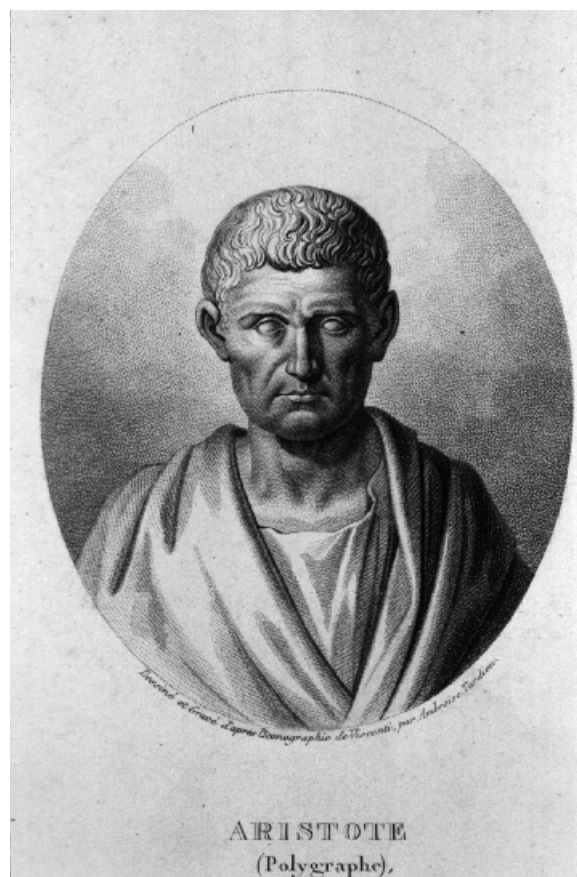
## ANCIENT CHINA, INDIA, AND GREECE

Writings about therapeutic exercises came from the Taoists priests in China and originated sometime before 1000 BC. These writings describe a type of exercise called Cong Fu that was able to relieve pain and other symptoms. Later, around 500 BC in ancient Greece, Herodicus, a Greek physician, wrote about an elaborate system of exercises called *Ars Gymnastica*<sup>1</sup> or *The Art of Gymnastics*. In ancient Greece around 400 BC, Hippocrates, who is considered the father of medicine, recognized the value of muscle strengthening using exercises (FIGURE 1-1). Hippocrates<sup>1</sup> was the first physician in his time to recommend therapeutic exercises to his patients because he understood the principle of muscle, ligament, and bone atrophy (wasting) due to inactivity. In regard to rehabilitation treatments, Hippocrates wrote about the utility of friction after ligament tears and dislocations, and recommended abdominal kneading massage and chest clapping massage to improve digestion and relieve colds. Hippocrates was the first to



**FIGURE 1-1** Hippocrates.

Source: © National Library of Medicine.



**FIGURE 1-2** Aristotle.

Source: © National Library of Medicine.

use electrical stimulation, applying torpedo-fish poultices for headaches. The torpedo fish has an electrical charge of approximately 80 volts to stun its prey. Also in the area of treatments, the Greek philosopher Aristotle<sup>1</sup> recommended rubbing massage using oil and water as a remedy for tiredness (FIGURE 1-2).

Around 180 BC, the ancient Romans<sup>1</sup> adopted a form of therapeutic exercises that they called gymnastics. The Roman gladiators and athletes used gymnastics in the Roman arenas and in popular exhibitions of athletics. Later, in the second century AD, Galen,<sup>1</sup> the renowned physician of ancient Rome, believed that moderate exercises strengthened the body, increased body temperature, allowed the pores of the skin to open, and improved a person's spiritual well-being (FIGURE 1-3). Galen<sup>1</sup> was also an authority on trauma surgery and musculoskeletal injuries. His extensive writings, advanced for his era, describe from a kinetic principle the roles of anatomy and physiology in human movement.



**FIGURE 1-3** Galen.  
Source: © National Library of Medicine.

## EUROPE AND AMERICA FROM THE 1500S TO THE 1900S

In Europe around the 1400s, after the Middle Ages, therapeutic exercises<sup>2</sup> were introduced in schools as physical education courses. During the 1500s, the first printed book on exercise, entitled *Libro del Exercicio* and written by Christobal Mendez of Jaen,<sup>2</sup> was published in Spain. During the 1600s and 1700s, more books were written about exercises. These works promoted moderate exercises, stating that exercises give the body agility and vigor and also have the ability to cleanse the muscles and ligaments of waste.<sup>2</sup>

In the United States, massage, hydrotherapy, and exercises were first introduced around the year 1700. These rehabilitation treatments were based on ideas originating mostly in England. They were further developed in the 1800s and early 1900s.

In Europe in 1723, Nicolas Andry,<sup>3</sup> a professor at the Medical Faculty in Paris, was the first scientist to relate

the movements created by exercises to the musculoskeletal system. Andry is considered to be the “grandfather”<sup>3</sup> of orthopedics.

During the 1800s, Per Henrik Ling,<sup>4</sup> a Swedish poet, fencing master, playwright, and educator, contributed to the growth of physical exercise by initiating the gymnastic movement. These gymnastic techniques, similar to Chinese manipulative therapy, were adopted in the 1800s by Dr. Johan Georg Mezger of Holland<sup>4</sup> (a Dutch practitioner). Dr. Mezger gave these types of manipulative therapy French names such as “effleurage,” “petrissage,” and “tapotement.” These techniques (describing some of Ling’s movements) became known as the Swedish massage.

Around the 1860s, George H. Taylor, an American physician<sup>5</sup> from Vermont who was the medical director of the Remedial Hygienic Institute in New York, introduced Ling’s Swedish gymnastics for the first time in America. Swedish gymnastics became very popular in American public schools and had a significant impact upon physical education classes. Ling’s exercises, consisting of passive and active movements, were also used to treat chronic disease conditions. In addition, Ling’s medical gymnastics contributed to the development of Swedish massage as a therapeutic activity. Although Ling’s system of exercise was effective, it required the continuous personal attention of a gymnast. In 1864, Gustav Zander,<sup>6</sup> a Swedish physician, invented different exercise machines that offered assistance and resistance to the patient.

Later, at the beginning of the 1900s, with the advent of World War I (1917), “reconstruction aides” (who began physical therapy in the United States) used Zander’s machines as well as Ling’s Swedish movement for the rehabilitation of disabled soldiers. In those early times, physical therapy was performed in various specialized rooms; one of the rooms was for “mechanotherapy” and contained Zander’s exercise machines. Zander’s apparatus seemed to work very well during the war.

At the beginning of the 1920s, after the passage of the Rehabilitation Bill in New Jersey, orthopedic surgeons<sup>7</sup> became enthusiastic about the future of rehabilitation and of “reconstruction aides or teachers of vocational and educational forms of work that are therapeutic in purpose.”<sup>7(p.39)</sup> An article written in February 1920 in the *Journal of the Medical Society of New Jersey* described modern developments in rehabilitation, especially for “industrially injured”<sup>7(p.43)</sup> individuals. It was considered that “the sooner an industrially injured man gets safely back

to work” the better it would be for his morale and physical well-being. In the 1920s, this required the injured worker to receive “active, voluntary joint-motion and muscle exercises.”<sup>7(p.44)</sup> It is interesting that in the 1920s, orthopedic surgeons believed that these forms of rehabilitation using active exercises were to be provided by a “reconstruction aide,” who was described as a combination of “the school teacher”<sup>7(p.46)</sup> and “the professional nurse.”<sup>7(p.46)</sup>

In the 1860s, electrical stimulation was first introduced in the United States as a therapeutic modality, having originated in Europe and been used in France, England, and Germany. In the 1890s, the American Electro-Therapeutic Association was formed. Members included interested U.S. practitioners who promoted specialized training in electrotherapy, electrotherapeutic research, and the use of reliable electrotherapeutic equipment. Also in the 1890s, Nikola Tesla<sup>8</sup> introduced diathermy as an electrotherapeutic modality; however, it was not until the 1900s that diathermy’s beneficial role as a deep heating agent for joints and the circulatory system was discovered.

In England around the beginning of the 1950s, a neurophysiologist (physician) named Herman Kabat<sup>9</sup> utilized newly discovered neurological concepts of stretch reflex, flexion reflex, and tonic neck reflex to develop neurological exercises called “proprioceptive facilitation.” Around 1968, Margaret Knott and Dorothy Voss expanded<sup>9</sup> proprioceptive neuromuscular facilitation (PNF) as a form of physical therapy intervention for patients with paralysis. As is done today, the PNF method was recommended and utilized for patients who had paralysis produced by stroke, cerebral palsy, or another neurological dysfunction. Additionally, regarding neurological exercises and rehabilitation, toward the end of the 1800s, H.S. Frenkel<sup>10</sup> of Switzerland was able to improve an ataxic (unstable) gait resulting from nerve cell destruction by repetitive attempts at supervised ambulation. Frenkel did not rely on equipment, but instead marked the floor for successive placement of the feet in walking (as we do today using Frenkel’s exercises). Frenkel advocated walking in groups of three to six patients with similar degrees of ataxia for long walking paths, insisting on repetitions.

In the United States during the 1900s, the area of therapeutic exercises was built up by physicians, physical therapists (PTs), surgeons, psychologists, and other scientists. All therapeutic exercises developed in the early 1900s greatly influenced the growth of physical therapy interventions. Robert Lovett’s<sup>11</sup> concept was an example

of such growth and development. Lovett, a professor of orthopedic surgery at Harvard, discovered in 1916 that muscle training exercises were the most important early therapeutic measures for polio treatment. Ten years later in 1926, Lovett’s idea was put into practice by his senior assistant, Wilhelmine G. Wright. Wright<sup>12</sup> developed the training technique of ambulation with crutches (using the upper extremity muscles) for patients who had paraplegia or paralysis caused by polio. She also introduced the manual muscle testing procedure in physical therapy. In 1928, Wright authored the book<sup>12</sup> *Muscle Function* (which she started with Dr. Lovett), in which she described the systematic method of manual muscle testing using palpation, gravity, external manual resistance, and the arc of active movement. Wright believed in the importance of muscle testing on polio patients and the use of stronger muscles to compensate for the weakness of muscles affected by polio. Between 1917 and the early 1950s, several PTs and rehabilitation clinicians<sup>12</sup> made changes to Wright’s method of muscle testing, taking into consideration variables such as a patient’s fatigue, body position, and incoordination. These clinicians included Florence Kendall, Signe Brunnstrom, Marjorie Dennen, and Catherine Worthingham.

Another example of the developments made to combat the devastating effects of paralysis caused by the polio epidemic was Charles Leroy Lowman’s<sup>13</sup> method of “hydrogymnastics.” In California in 1924 he converted a lily pond into two treatment pools for the treatment of spasticity and paralysis caused by cerebral palsy. In the 1920s at Warm Springs, Georgia, Carl Hubbard<sup>13</sup> (an American engineer) installed the first metal tank (known today as the Hubbard tank) in a hospital for hydrogymnastics use. In 1928, U.S. President Franklin D. Roosevelt,<sup>13</sup> who had polio, used the hydrogymnastics therapy at Warm Springs Institute for rehabilitation. During the late 1920s, Roosevelt developed the institute known today as The Georgia Warm Springs Foundation, which has become an international polio treatment facility.

In the area of exercise for vascular disease, in 1924 Leo Buerger (a urologist) and Arthur W. Allen (a surgeon) created the Buerger-Allen exercises<sup>14</sup> for arterial insufficiency in the legs. The exercises used the effects of gravity and posture and applied those to the vascular musculature and blood circulation. Additionally, during the 1900s physicians began to treat back pain more efficiently. This was due to the use of x-rays to visualize and identify

bone abnormalities and the dysfunction of curvature of the spine. An example of exercise development for back pain was Joel E. Goldthwait's discovery that the reasons for backaches were faulty posture<sup>15</sup> and habits. As a result, in 1934, Goldthwait and his colleagues wrote the book *Essentials of Body Mechanics*. In regard to back pain and exercises, in 1953, Paul C. Williams proposed a series of postural exercises, known today as the Williams exercises. These helped to strengthen the spine flexors and extensors and relieve back pain. Still in regard to exercises, around 1934, Ernest A. Codman, a Boston surgeon, introduced shoulder exercises known as Codman pendulum exercises. He pointed out that a diseased supraspinatus muscle could relax if the shoulder is abducted in the stooping position, allowing the arm to be under the influence of gravity. In the 1920s and 1930s, additional developments in the area of exercise were attributed to surgeons' findings that exercises could be helpful after surgery and that customary bed rest should be eliminated.

In 1938, Daniel J. Leithauser,<sup>16</sup> who performed appendectomies, was amazed to see that one of his patients who did not follow the usual bed rest routines was able to rapidly return to daily activities. Leithauser<sup>16</sup> prescribed early rising and physical activity for all postoperative appendectomies and abdominal surgeries. By 1947, there were many "convalescent centers," in the United States where patients were prescribed "convalescent exercises" or "reconditioning exercises" to counteract the deconditioning effect and the abuse of rest. In these centers, patients performed exercises in groups according to the **disability**. There were ankle classes, shoulder classes, or wheelchair basketball for patients who had paraplegia. Special centers were also created for major disabilities; for example, the centers for patients with amputations required PTs to exercise the amputated extremity early and through maximum range of motion to prepare it for the prosthesis.

In 1945, much of the greatest stimuli to the development of exercises came from an Alabama physician, Thomas DeLorme. Following his own knee surgery, DeLorme<sup>17</sup> found that he could rapidly restore his quadriceps muscles to full strength by increasing the resistance applied to the exercising muscles. DeLorme's method first introduced the technique of progressive resistive exercise (PRE),<sup>17</sup> which is still used today.

During the second half of the 1900s, the area of therapeutic exercises in the United States was advanced tremendously by the arrival of isokinetic and biofeedback

exercises. For example, in 1967 the Cybex I Dynamometer was introduced based on Helen Hislop and James Perrine's concept of isokinetic exercise. Hislop and Perrine found that muscular performance can be reduced to the physical parameters of force, work, power, and endurance, and that specificity of exercise should be determined by an exercise system designed to control each training need. Another type of exercise called biofeedback was also introduced in the second half of the 1900s as a result of advances in scientific behavioral psychology and clinical electromyography. Furthermore, Williams's back-flexion exercises were complemented in the 1950s and 1960s by Robin McKenzie's back-extension exercises that relieved pressure posteriorly on the spinal disk. Swiss ball exercises,<sup>18</sup> developed by physiotherapists in Switzerland in the 1960s, found their way to the United States in the 1970s and became popular in physical therapy rehabilitation in the 1980s.

## History of the Physical Therapy Profession

The creation of the physical therapy profession centered around two major events in U.S. history: the poliomyelitis epidemics and the negative effects of World War I and World War II. The profession can be compared with a living entity, changing from an undeveloped, young occupation in its formative years (1914 to 1920) to a firm, growing establishment in its development years (1920 to 1940). As a mature profession, during its fundamental accomplishment years (1940 to 1970), physical therapy was able to achieve significant organizational, executive, and educational skills. In the mastery years (1970 to 1996), the profession acquired greater control, proficiency, and respect within the healthcare arena, growing largely in the areas of education, licensure, specialization, research, and direct access. From 1996 to 2005, in its adaptation years, physical therapy had to adapt, review, and make changes in its objectives and goals due to political, social, and economic changes in the United States. Additionally, the profession went through rapid educational expansion and research growth, and significant developmental and scientific goals were achieved. From 2006 to the present, in its vision and scientific pursuit years, physical therapy has been emerging as a vigorous participant in U.S. healthcare reform, having large responsibilities in the areas of research, education, and sociopolitical transformations.

## FORMATIVE YEARS: 1914 TO 1920

### Division of Special Hospitals and Physical Reconstruction

In the United States, physical therapy had its beginnings between 1914 and 1919, in a time known as the Reconstruction Era. Prior to the “Great War” (World War I), most Americans regarded disability as irreversible, requiring little or no medical intervention. The war changed this concept of irreversibility because of the large number of young U.S. men returning home as disabled veterans. As mentioned prior, physical therapy was created because of World War I and the poliomyelitis epidemics. These two devastating events in U.S. history brought a great degree of disease and disability to U.S. society. The first major outbreak of poliomyelitis occurred in New York State in 1916.<sup>19</sup> The methods of treatment at that time<sup>19</sup> were bed rest, isolation, and splinting and casting of the person’s legs. Unfortunately, these forms of healing increased the individual’s weakness in the legs and back, and as a result, the person required some form of exercise and physiotherapy.

Prior to and during World War I, support for people with disabilities had been growing gradually.<sup>19</sup> For example the Medical Department of the U.S. Army had two divisions that influenced the growth of physical rehabilitation in the United States, the Division of Orthopedic Surgery and the Division of Physical Reconstruction. The newly created Division of Physical Reconstruction was needed to apply physiotherapy treatments such as massage and mechanical hydrotherapy to wounded soldiers. The Division of Physical Reconstruction drew its “training corps” personnel from schools of allied health therapies and physical training.<sup>19</sup> The Division of Physical Reconstruction had three sections:<sup>19</sup> surgery (including general, orthopedic, and head surgery) and neuropsychiatry, education, and physiotherapy (including gymnasiums and equipment).

In April 1917, the United States entered World War I. The U.S. Congress authorized the military draft and passed legislation to rehabilitate all servicemen permanently disabled from war-related injuries. In August 1917, the Surgeon General of the United States, William Gorgas, authorized the creation of the Division of Special Hospitals and Physical Reconstruction.<sup>20</sup> The role of the division was to give soldiers who were disabled “reconstruction therapy.” The people involved in the reconstruction therapy

were newly trained physical reconstruction aides. They consisted of a handful of physicians called orthopedists and 1,200 young women called reconstruction aides. These people were the physical therapy and occupational therapy pioneers<sup>20</sup> who treated the injured soldiers from World War I. The division included two different groups of reconstruction aides. One group who assisted physicians was to become today’s PTs. They provided exercise programs, massage, hydrotherapy, and other forms of therapeutic modalities including patient education. The other group of reconstruction aides was to become today’s occupational therapists. They provided training in the vocational skills that would help wounded soldiers return to work.

These forms of rehabilitation enabled soldiers to return either to combat or to their civilian prewar lives.<sup>20</sup> The division had almost a dozen small facilities set up in Europe and more extensive centers and hospitals in New York Harbor; Lakewood, New Jersey; Tacoma Park, Maryland (a suburb of Washington, D.C.); Fort McPherson, Georgia; and San Francisco, California. Each hospital had a physical therapy unit containing a gymnasium, a whirlpool room, a massage room, a pack room, and other rooms for mechanotherapy<sup>20</sup> and “electricity” (electrotherapy). The mechanotherapy room was an exercise room equipped with various apparatuses such as pulley-and-weight systems, trolleys, and ball-bearing wheels.

From its creation, the division recruited unmarried women between the ages of 25 and 40 to be trained as reconstruction aides. Applicants who had certificates showing practical and theoretical training in any of the treatments performed such as hydrotherapy, electrotherapy, mechanotherapy, or massage received priority and were accepted first. Nevertheless, they still were given additional preparation in all other necessary treatments.

### First Physical Therapists: Marguerite Sanderson and Mary McMillan

The first reconstruction aides who made big contributions to the physical therapy profession during the Reconstruction Era were Marguerite Sanderson and Mary McMillan. Marguerite Sanderson was a physiotherapist who graduated from the Boston Normal School of Gymnastics and used to work with Dr. Joel Goldthwait, an orthopedic surgeon who later became the chairman of the War Reconstruction Committee of the American Orthopedic Association. Because of her prior physiotherapy experience, in 1917, Dr. Goldthwait appointed Sanderson as the first



Supervisor of Reconstruction Aides. Her role was to recruit and arrange for training of reconstruction aides and also send them to Europe to help the wounded soldiers. In 1922, Sanderson married and withdrew from active participation in the school.

The training program for the reconstruction aides took place at Walter Reed General Hospital. The program at Walter Reed was assigned to a reconstruction aide named Mary Livingston McMillan (**FIGURE 1-4**). Mary McMillan was a mature, educated woman who was born in the United States from Scottish ancestry. When she was 5 years old, her mother and sister died of consumption (tuberculosis). Mary was sent to live with relatives in Liverpool, England. Although acquiring a higher education was unusual at that time for a young woman, as an avid and eager learner Mary received a college degree in physical education and a postgraduate degree in her



**FIGURE 1-4** Mary McMillan, one of the founders and the first president of the American Physical Therapy Association (WWI Era/1918/1919).

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chosen career, the science of physical therapy. McMillan's physical therapy degree included topics such as corrective exercises, massage, electrotherapy, aftercare of fractures, dynamics of scoliosis, psychology, neurology, and neuroanatomy.<sup>20</sup> In 1910, McMillan took her first professional position in Liverpool, England, working with Sir Robert Jones, nephew and professional heir of the great orthopedist Hugh Owen Thomas. Jones, an orthopedic physician, was renowned for using the Thomas splint (invented by his famous uncle) and performing progressive massage and orthopedic manipulations (invented by the French orthopedist Lucas-Championniere and British surgeon James B. Mennell). Lucas-Championniere and Mennell were pioneers of the principle that following an injury, early movement can enhance healing and prevent disability.

In 1916, McMillan returned home to her family in Massachusetts. Because of her education and experience, she was hired immediately at the Children's Hospital in Portland, Maine, where for 2 years she was director of massage and medical gymnastics, treating children with scoliosis, congenital hip dislocations, and other childhood orthopedic bone and joint abnormalities.<sup>20</sup> In 1918, at the recommendation of Sir Robert Jones, Elliott Brackett, a Boston orthopedist and one of the organizers of the army's Reconstruction Program, asked McMillan to consider service with the U.S. Army. In February 1918, McMillan was sworn in as a member of the U.S. Army Medical Corps. As a reconstruction aide she was assigned to Walter Reed General Hospital in Tacoma Park, Maryland. Shortly after, in June 1918, due to her experience and education in England, McMillan was asked to go to Reed College in Portland, Oregon, to train reconstruction aide applicants in the practical, hands-on segment of the War Emergency Training Program. With her contribution, Reed College's physical therapy curriculum became the standard by which other emergency war training programs were measured. In January 1919, McMillan was awarded the position of Chief Reconstruction Aide<sup>20</sup> in the department of physiotherapy at Walter Reed General Hospital.

Between 1919 and 1920, the number of physical therapy reconstruction aides was reduced primarily because of a major postwar decrease in military hospitals (at home and overseas). The number of hospitals shrank from 748 to 49. Despite this cutback, the army's commitment to maintain physical therapy as an important part of its medical services was established (**FIGURE 1-5**). In 1920, McMillan resigned her duties in the army because she felt her work



**FIGURE 1-5** Reconstruction aides treat soldiers at Fort Sam Houston, Texas, in 1919 (WWI Era).

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was essentially completed. She returned to civilian life in Boston as a staff therapist in an orthopedic office. In 1921, McMillan published her book, *Massage and Therapeutic Exercise*.

### DEVELOPMENT YEARS: 1920 TO 1940

#### The Development of Professional Organization

During her work as a reconstruction aide, Mary McMillan was convinced that physical therapy had a vital future role in America's health care. Before resigning her duties in the army, McMillan wanted to maintain a nucleus of trained people who were capable of carrying out such a role. She contacted 800 former reconstruction aides and civilian therapists and received 120 enthusiastic responses. On January 15, 1921, at Keene's Chop House, an eatery in Manhattan, New York,<sup>20</sup> McMillan and 30 former reconstruction aides organized themselves into the first association of PTs. The organization was called the American Women's Physical Therapeutics Association (AWPTA).

McMillan was elected president. The role of the AWPTA was to establish and maintain professional and scientific standards for individuals who were involved with the profession of physical therapeutics.<sup>19</sup> The members of the AWPTA<sup>19</sup> were graduates of recognized schools of physiotherapy and of physical education programs trained in massage, therapeutic exercises, electrotherapy, and hydrotherapy. The executive committee of the AWPTA represented geographically diverse reconstruction aides; the first year there were 274 members coming from 32 states.

#### The P.T. Review and Constitution

The official publication of the Association, which first appeared in March 1921, was called the *P.T. Review*.<sup>20</sup> It was published quarterly and included the Association's constitution and bylaws, professional interest articles, and even a column called "S.O.S." for job classified advertisements. Also in 1921, the first textbook written by a physiotherapist (Mary McMillan) was published.

The first edition of the *P.T. Review* reported the full text of the constitution and bylaws of the Association. The basic reasons for the Association's existence, as described in its constitution,<sup>20</sup> were to have professional and scientific standards for its members, to increase competency among members by encouraging advanced studies, to promulgate medical literature and articles of professional interest, to make available efficiently trained members, and to sustain professional socialization.<sup>20</sup> The Association's bylaws specified three categories of membership in the Association: charter members, who were the reconstruction aides in physiotherapy; active members, who were graduates of recognized schools of physiotherapy or physical education; and honorary members, who were graduates of medical schools.

### American Physiotherapy Association

At its first conference in Boston in 1922, the Association changed its name to the American Physiotherapy Association because although its members were all women, they recognized that men also practiced physiotherapy. At that time, there were a few male reconstruction aides who provided physiotherapy services during World War I.

In 1922, new schools of physiotherapy were opened at Harvard Medical School and in New York City. The graduates of these schools were called physiotherapists. By 1923 the membership in the Association had risen appreciably, and McMillan stepped down as president, giving way to a new president, one of the former reconstruction aides, Inga Lohne.<sup>20</sup>

In 1926, the Committee on Education and Publicity was formed to draft the minimum standard curriculum for schools offering a complete course in physical therapy. The committee's report, which was published in 1928,<sup>20</sup> was recommending a 9-month course with 33 hours of physical therapy–related instruction per week for a total of 1,200 hours. The entrance requirement was graduation from a recognized school of physical education or nursing. In 1930, there were 11 schools<sup>20</sup> that met or exceeded the minimum standards set by the committee. By 1934, there were 14 approved physiotherapy schools<sup>20</sup> including higher standard educational institutions such as Harvard Medical School in Boston, Massachusetts; Stanford University Hospital in Stanford, California; and the College of William and Mary in Williamsburg, Virginia.

In the early years, the American Physiotherapy Association tried to stay side by side with the medical profession.

During the 1920s and 1930s, physical therapy physicians became organized<sup>21</sup> in order to belong to the American Medical Association (AMA). The AMA recognized their efforts and educated other physicians about the value of physical therapy in rehabilitating World War I veterans. As a result, in 1925, a group of physical therapy physicians founded<sup>21</sup> the American College of Physical Therapy (ACPT). Later that year, the ACPT joined the AMA and changed its name to the American Congress of Physical Therapy. Physical therapy physicians decided to call themselves “physiatrists.” Although their name was not officially changed until 1946, the physiatrists established the American Registry of Physical Therapy Technicians to separate the physiotherapists from the medical profession.

In 1930, the American Physiotherapy Association was incorporated and decided to work with the AMA to create standards of education for physiotherapists, to encourage the regulation of physical therapy practice by law, and to cooperate with, or under the direction of, the medical profession to provide a central registry for physiotherapists.<sup>22</sup> Consequently, by the 1930s, due to pressure from the AMA, registered physiotherapists were called technicians and settled to work under the referral of physical therapy physicians. It seems, however, that members of the AMA were concerned that the public might consider physiotherapists to be physicians, because their designation as physiotherapists ended in “ists,” the same as radiologists, orthopedists, and so on. The AMA wanted no confusion in regard to medical school education of physiatrists as compared to physiotherapists. Finally, in the 1940s, the name physiotherapists changed to physical therapists.

### Poliomyelitis and the Great Depression

By the 1930s, members of the American Physiotherapy Association were confronted with two calamities<sup>20</sup> in U.S. life—the growing severity of poliomyelitis and its resulting infantile paralysis (which began in the summer of 1916) and the Great Depression of 1929 (FIGURE 1-6). The poliomyelitis epidemic started in 1916 and continued into the 1930s and 1940s. As an example of the high incidence and magnitude of this disease, between May and November 1934, approximately 2,500 cases of poliomyelitis were treated at just one hospital,<sup>19</sup> the Los Angeles County General Hospital. The fact that the President of the United States, Franklin Delano Roosevelt, was treated for poliomyelitis by physiotherapists generated large public recognition of the physical therapy profession. At that time, physical



**FIGURE 1-6** PTs and physicians work together to treat children at a New York poliomyelitis clinic in 1916 (WWI Era).

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therapy for poliomyelitis consisted of hydrotherapy, exercises, massage, heat and light modalities, and assistive and adaptive equipment.<sup>19</sup> For home care, especially in rural areas, the physiotherapists provided “homemade” braces and splints.

In 1929, the Depression closed many hospitals and private medical practices, substantially reducing the number of physical therapy services.

Because the country was looking for a cure for poliomyelitis, in 1937, the National Foundation for Infantile Paralysis was founded. The foundation, using federal funding and money from charitable organizations such as the March of Dimes, opened new facilities and lent equipment to families and hospitals for polio aftercare. The National Foundation for Infantile Paralysis also financially contributed to the development of physical therapy education and

the growth of physical therapy schools. PTs who had no work during the Great Depression were able to pick and choose positions. They were needed to work in diagnostic clinics, outpatient centers, orthopedic hospitals, convalescent homes, schools for children with disabilities, and restorative services.

In 1937, although the physiotherapists were still dominated by their technician mindsets, their plans for the future were progressive, and included unity, research, and provision of educational standards. For example, the aims of the American Physiotherapy Association in 1937 were:<sup>19</sup>

- To form a nationwide organization that would establish and maintain professional and scientific standards for its members
- To promote the science of physical therapy

- To aid in the establishment of educational standards and scientific research in physical therapy
- To cooperate with, and to work only under the prescription of, members of the medical profession
- To provide available information to those interested in physical therapy
- To unite several chapters
- To create a central registry (available for the medical profession) that will make physiotherapists the only “trained assistants”<sup>19(p.6)</sup> in physical therapy

### FUNDAMENTAL ACCOMPLISHMENT YEARS: 1940 TO 1970

#### The Professional and Educational Developments of Physical Therapy

During World War II, the American Physiotherapy Association continued to grow under its experienced president, Catherine Worthingham.<sup>20</sup> She was the first PT to hold a doctoral degree in anatomy and served as president of the Association from 1940 to 1945. The governance of the American Physiotherapy Association changed substantially to accommodate increased growth and responsibilities and a more national approach. In the summer of 1941, six months before the bombing of Pearl Harbor, the first War Emergency Training Course of World War II was initiated at Walter Reed General Hospital. Emma Vogel<sup>20</sup> directed the Walter Reed General Hospital program to train PTs (FIGURE 1-7). The course at Walter Reed consisted of 6 months of concentrated didactic instruction followed by 6 months of supervised practice at a military hospital.

The physiotherapists graduating from the Emergency Training Course were no longer called reconstruction aides but instead were physiotherapy aides. In 1943, the U.S. Congress passed a bill stating that graduates of the Emergency Training Course should be called physical therapists. Inadvertently, with the change of their titles, PTs started to have increased recognition and wide-ranging responsibilities. These new tasks were related to the treatment of wounded veterans including rehabilitation for amputations, burns, cold injuries, wounds, fractures, and nerve and spinal cord injuries. Additionally, immediately after the war, the U.S. government allocated \$1 million for the enhancement of prosthetic services. This gave PTs the opportunity to participate in the teaching and training programs of the 25-year-old Artificial Limb Program at the University of California at Berkeley,



**FIGURE 1-7** Emma Vogel directed the Walter Reed General Hospital program for PTs. After the outbreak of World War II, Vogel was deployed to direct the War Emergency Training courses at 10 Army hospitals (Post WWI through WWII Era).

Source: Reprinted from Murphy W: *Healing the Generations: A History of Physical Therapy and the American Physical Therapy Association*. Alexandria, American Physical Therapy Association, 1995; *Commemorative Photographs; APTA—75 Years of Healing the Generations*, with permission of the American Physical Therapy Association. This material is copyrighted, and any further reproduction or distribution is prohibited.

New York University, and the University of California at Los Angeles. Furthermore, in 1946, because of the passing of the Hill-Burton Act and founding of a nationwide hospital-building program, PTs increased their hospital-based<sup>19</sup> practice. The work of PTs expanded even more in the 1950s with the outbreak of the Korean War.

In 1944, the American Physiotherapy Association membership voted for a separate internal legislative branch called the House of Delegates.<sup>20</sup> The House of Delegates had the same legislative powers as it does today—to amend or repeal the bylaws of the Association. In 1946, physical therapy physicians practicing physical medicine officially changed their specialty name to physiatrist. In the same year, the American Physiotherapy Association changed its name to its current one, the **American Physical Therapy Association (APTA)**. By 1959, membership in the APTA had increased to 8,028 PTs.

In 1947, the length of physical therapy schools' curricula increased from 9 months to 12 months. By the 1950s, there were 31 accredited schools in the United States, 19 of them offering 4-year integrated bachelor degree programs. By 1959, most of the states had licensure laws adopting the Physical Therapy Practice Act. In 1951, the Joint Commission on Accreditation of Hospitals was formed, raising the standards for institutional staffing and health care.

### The Polio Vaccine and the Journal of the American Physical Therapy Association

Because new cases of polio were seen every year, PTs were called upon from all over the country to help either part-time or full-time as volunteers dealing with polio epidemics. In 1952, there were 58,000 cases of poliomyelitis in the United States. Between 1948 and 1960 nearly 1,000 PTs participated in the polio volunteer program. In 1954, 63 PTs were dispatched to 44 states to help with clinical studies of the polio vaccine developed by Jonas Salk. After successful clinical trial inoculations of 650,000 children, the Salk vaccine was determined to be safe and was approved for commercial production in 1955 by the Food and Drug Administration. Finally, in 1955, a massive national vaccination program started using the Salk vaccine. As a result, poliomyelitis cases were virtually eradicated.

Jessie Wright, PT, MD, was one of the PTs who helped with polio clinical studies by evaluating patients' strength. In 1954, Wright and her staff introduced the abridged muscle grading system. Wright, who specialized in physical medicine and rehabilitation at the University of Pittsburgh, Pennsylvania, was a visionary in regard to helping patients achieve function. Wright believed that "the first goal of physical therapy was to relax tight muscles"<sup>11(p.77)</sup> allowing complete range of motion in the joints and as a result giving the patient "functional use of residual power, helpful body mechanics and assistive devices."<sup>11(p.78)</sup>

The role of the PT in the 1950s expanded<sup>19</sup> from a technical position to that of a professional practitioner. Private practices expanded and, in 1957, the Physical Therapy Fund was established to foster scientific, literary, and educational programs.<sup>20</sup> PTs' licensure started in 1913 in Pennsylvania and in 1926 in New York; it expanded during the 1950s and by 1959,<sup>20</sup> 45 states and the territory of Hawaii offered licensure.

In 1964, the APTA formed a committee on research in order to improve the development of scientific inquiry. In regard to dissemination of information (including scientific discovery) among the members of the physical therapy profession, just 2 years earlier (1962), the APTA changed the

name of the official journal, the *P.T. Review* to the *Journal of the American Physical Therapy Association*. In 1963 the journal modified its format and expanded its content with the help of its editor, Helen Hislop.<sup>20</sup> In 1964, the journal changed its name to the *Journal of Physical Therapy*. Later, the name was changed to *Physical Therapy*.

### The Beginning of Physical Therapy Assistants

In the 1960s the U.S. population was changing, primarily because of the doubling of the number of elderly, but also because people were becoming more health conscious. As with other health professions, physical therapy was expanding rapidly with a high demand for physical therapy services. In addition, the change in physical therapy insurance reimbursement (through diagnostic related groups introduced by Medicare) and the enactment in 1965 and 1966 of Medicare and Medicaid programs created an even greater demand for PTs. As a result, in 1967 the APTA adopted a policy statement that set the foundation for the creation of the physical therapy assistant and the establishment of educational programs for the training of physical therapy assistants. The policy statement adopted by the House of Delegates recommended the following:<sup>20</sup>

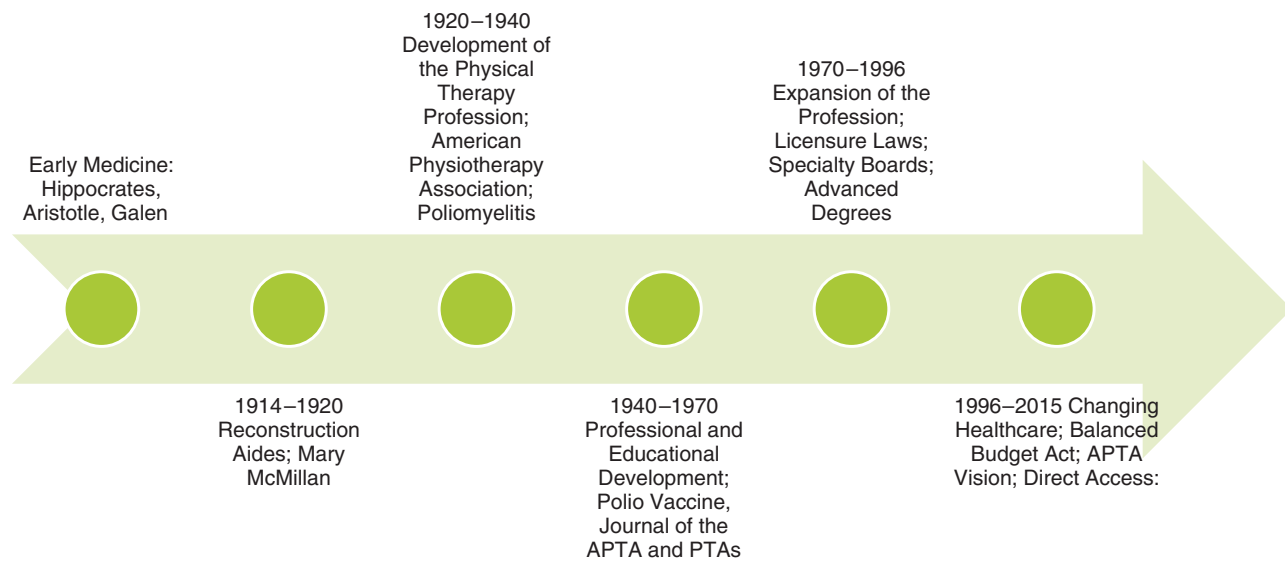
- The APTA had to establish the standards for physical therapy assistant education programs.
- A supervisory relationship existed between the PT and the physical therapy assistant.
- The functions of assistants were to be identified.
- Mandatory licensure or registration was encouraged.
- Membership in the APTA was to be established for the assistants.

By 1969, the occupational title changed from physical therapy assistant to physical therapist assistant (PTA). Also, training programs were to be called physical therapist assistant programs. At that time there were already two colleges in the country that enrolled students in their programs: Miami Dade Community College in Miami, Florida, and St. Mary's Campus of the College of St. Catherine in Minneapolis, Minnesota.

## MASTERY YEARS: 1970 TO 1996

### The Societal Developments of Physical Therapy

In 1969, the first 15 PTAs graduated with associate degrees from Miami Dade College and College of St. Catherine. By 1970 there were nine PTA education programs, mostly due to federal financial assistance to junior colleges. In the same



**FIGURE 1-8** Timeline.

year, the APTA offered temporary affiliate membership to PTAs. By 1973, eligible PTAs were admitted as affiliate members in the national association, having the right to speak and make motions, to hold committee appointments, and to chapter representation in the House of Delegates. In 1983, PTAs formed the Affiliate Special Interest Group, and in 1989 the House of Delegates approved the creation of the Affiliate Assembly, which gave PTAs a formal voice in the Association. The first president of the Affiliate Assembly was Cheryl Carpenter-Davis, PTA, MEd.

### The Expansion of the Physical Therapy Profession

During the 1970s and 1980s, the physical therapy profession continued to grow and expand. Because of the establishment of the Occupational Safety and Health Administration (OSHA) by the Department of Labor, physical therapy practices related to prevention, work management, and job injuries and compensation also developed. This contributed to PTs' advancement of practice from hospital-based to private. In 1972, Congress added physical therapy services to the Social Security Act as services that were to be reimbursed<sup>20</sup> when they were furnished by an individual PT in his or her office or in the patient's home. In 1975, the Individuals with Disabilities Education Act (IDEA) was passed. This helped physical therapy expand into treatment of children with disabilities in public schools.

In 1971, the AMA dissolved the American Registry, and by 1976, all states had physical therapy licensure laws in place. In 1981 and 1982, the House of Delegates adopted the policy that PT practice that was independent

of practitioner referral was ethical<sup>19</sup> (as long as it was legal in that specific state). This separated PTs from the physician's control, giving them the right to practice without a physician's referral.

During the early 1970s, the APTA formed sections for state licensure and regulations, sports physical therapy, pediatrics, clinical electrophysiology, and orthopedics. The state licensure and regulations section later became the health policy, legislation, and regulation section. In 1976, the first combined sections meeting took place in Washington, D.C. In 1977, the APTA, through the Commission on Accreditation in Physical Therapy Education, became the sole accrediting agency for all educational programs for PTs and PTAs in the United States, Canada, and Europe.

In 1978, the American Board of Physical Therapy Specialties was created by the APTA to allow members a mechanism to receive certification and recognition as a clinical specialist in a certain specialty area. During the late 1970s, the sections on obstetrics and gynecology (now called women's health) and on geriatrics were created. By 1985, the American Board for Physical Therapy Specialties—Certified Cardiopulmonary Specialists was formed, giving cardiopulmonary specialist certifications. Shortly, other specialty certifications followed such as orthopedic, pediatric, electrophysiology, neurology, and sports. In 1983, the APTA purchased its first four-story building in Alexandria, Virginia.

In 1990, the Americans with Disabilities Act assured the involvement of PTs as consultants to guarantee every individual with disabilities rightful access to all aspects

of life. Many major changes occurred during the 1990s; managed care, point of service plans, and other alternative organizational structures such as health economics resources also impacted physical therapy delivery. Nevertheless, physical therapy practice developed in the areas of work conditioning, women's health, and work hardening.<sup>19</sup>

During the last two decades of the twentieth century, the following major developments occurred in the physical therapy profession:

- In 1980, the House of Delegates established its goal to raise the minimum entry-level education in physical therapy to a postbaccalaureate degree.
- During the early 1980s, the sections on veterans' affairs, hand rehabilitation, and oncology were established.
- In 1986, the *PT Bulletin* was initiated. In the same year, setting goals and objectives became part of the APTA's annual self-review process.
- In 1989, the House of Delegates approved the formation of the Affiliate Assembly, composed entirely of PTA members. In this way, PTAs had a formal avenue to come together and discuss issues that directly concerned them.
- By 1988, direct access was legal in 20 states, providing patients and clients the ability to seek direct physical therapy services without first seeing a physician.
- The academic preparation of PTs changed from a bachelor's degree to postbaccalaureate degrees. By January 1994, 55 percent of physical therapy education programs were at the master's level.
- In 1995, the American Board of Physical Therapy Specialties inaugurated nationwide electronic testing and the APTA celebrated the 75th anniversary of the association and the physical therapy profession.
- Also in 1995, the APTA hosted the 12th World Confederation for Physical Therapy Congress in Washington, D.C. The Congress had record-breaking crowds.<sup>19</sup>
- In 1995, the APTA received representation on the AMA Coding Panel, facilitating a better development of PT practice codes.

## ADAPTATION YEARS: 1996 TO 2005

### The Balanced Budget Act

In August 1997, President Clinton signed the Balanced Budget Act (BBA) to eliminate the Medicare deficit. The Balanced Budget Act, which took effect in January 1999,

applied an annual cap of \$1,500 (for both physical therapy and speech therapy services) per beneficiary for all outpatient rehabilitation services. As an effect of the Balanced Budget Act and its resultant reduction in rehabilitation services to Medicare patients, many new graduate PTs and PTAs could not find jobs. Also, some experienced PTs and PTAs suffered an appreciable decrease in income and in the number of working hours. Due to pressure from the Association, its members, patients, and the general public, in November 1999 President Clinton signed the Refinement Act, which suspended the \$1,500 cap for 2 years in all rehabilitation settings starting on January 3, 2000. Nonetheless, the Balanced Budget Act was detrimental to the treatment of many Medicare patients and also created a hardship for PTs and PTAs for at least 3 years. An APTA survey<sup>23</sup> in October 2000, found that as a result of the Balanced Budget Act, PTAs were hurt the most, with an unemployment rate of 6.5 percent. The PTs also reported that their hours of employment had been involuntarily reduced. In March 2001, the same survey discovered that the unemployment rate among PTAs had improved, going down to 4.2 percent. PTs also reported an improvement, with the reduction in working hours only 10.8 percent. The reduction in the number of working hours for PTAs was even greater than the PTs, at 24.5 percent in October 2000; in March 2001 it went down to 19.8 percent.

During 2005, the effects of the Balanced Budget Act of 1997 were still influencing the future of rehabilitation services. On February 17, 2005, the APTA stated in a news release that "Senior citizens across the country are looking to the 109th Congress to keep much needed rehabilitation services available under Medicare."<sup>24</sup> Rehabilitation providers and patients urged Congress to pass the Medicare Access to Rehabilitation Services Act of 2005 to eliminate the threat that seniors and individuals with disabilities would have to pay out of pocket for rehabilitation or to alter the course of their rehabilitation care. This Act was considered significant to repeal the cap that was originally instituted through the Balanced Budget Act (BBA) of 1997. From 1997 to the beginning of 2005, Congress enforced a moratorium three times that delayed implementation of the cap. On December 31, 2005, the moratorium expired. As a result, on January 1, 2006, the Medicare cap was reimplemented by the Centers for Medicare and Medicaid Services (CMS). From January 1, 2006, to December 31, 2006, the dollar amount of the therapy cap was \$1,740 for physical therapy



and speech language pathology combined and \$1,740 for occupational therapy.

The APTA has been working diligently during each Congressional session to reduce the drastic impact the BBA has had on patient care. Although the therapy cap went into effect in 2006, because of the pressure from the APTA, clinicians, and consumer groups, Congress authorized Medicare to allow exceptions for beneficiaries who needed additional rehabilitation services based on diagnosis and clinicians' evaluations and judgments. Consequently, Congress acted to extend these exceptions through December 31, 2009. On January 1, 2010, without Congressional action, authorization for exceptions to the therapy caps expired. The APTA states on its website that "on March 23rd, 2010, President Obama signed H.R. 3590, the Patient Protection and Affordable Care Act, making it law." This Act includes a healthcare reform package that extended the therapy cap exception process until December 31, 2010. For details of the Act and more information, visit the APTA's website at: [www.apta.org](http://www.apta.org).

### APTA Events

In 1999, two significant events affected the APTA: the suspension of the \$1,500 Medicare cap and the publication of the *Normative Model of Physical Therapist Assistant Education: Version 1999*, which guides PTA education programs. In 2000, the Association adopted the new "Evaluative Criteria for the Accreditation of Education for Physical Therapist Assistants," launched *PT Bulletin* online, and published the *Normative Model for Physical Therapist Professional Education: Version 2000*. In 2001, the Association introduced the second edition of the *Guide to Physical Therapist Practice* and worked hard to maintain PTs' rights in certain states to perform manipulations and provide orthotics and prosthetics within the scope of physical therapy practice. The Association launched *Hooked on Evidence on the Web* in 2002 to help clinicians review the research literature and utilize the information to enhance their clinical decision making and practice. In January 2002, all physical therapy educational programs changed to the master's level. In the same year, Pennsylvania became the 35th state to achieve direct access, and the APTA released the *Interactive Guide to Physical Therapist Practice*. In 2003, the Association built support in Congress for the Medicare Patient Access to Physical Therapists Act to allow



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licensed PTs to evaluate and treat Medicare patients without a physician's referral.

### VISION AND APPLICATION OF SCIENTIFIC PURSUIT YEARS: 2006 TO TODAY

From 2006 to today, the roles of PTs have become more dependent on the application of the scientific method in clinical practice and finding new evidence-based approaches for disease prevention and health promotion. PTAs were delegated with important responsibilities as the only individuals permitted to assist PTs in selected interventions (under the direction and supervision of PTs).

#### The American Physical Therapy Association's Vision

The House of Delegates updated the vision statement in 2013. The new vision for the APTA is "Transforming society by optimizing movement to improve the human experience."<sup>25</sup>

The previous vision statement was created in 2000 and guided the Association for 13 years. The guiding principles were critical for directing the profession to its current vision statement.<sup>26</sup>

Vision 2020 states: "By 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy, recognized by consumers and other healthcare professionals as the practitioners of choice to whom consumers have direct access for the diagnosis of, interventions for, and prevention of impairments, **functional limitations**, and disabilities related to movement, function, and health."

APTA Vision Statement for Physical Therapy 2020 includes the following:<sup>26</sup>

- Physical therapy will be provided by PTs who are doctors of physical therapy and who may be board-certified specialists.
- Consumers will have direct access to PTs in all environments for patient/client management, prevention, and wellness services.
- PTs will be practitioners of choice in patients/clients' health networks and will hold all privileges of autonomous practice.
- PTs may be assisted by PTAs who are educated and licensed to provide PT-directed and supervised components of interventions.
- Guided by integrity, life-long learning, and a commitment to comprehensive and accessible health programs for all people, PTs and PTAs will render evidence-based services throughout the continuum of care and improve quality of life for society.
- PTs and PTAs will provide culturally sensitive care distinguished by trust, respect, and an appreciation for individual differences.
- While fully availing themselves of new technologies, as well as basic and clinical research, PTs will continue to provide direct patient/client care.
- PTs and PTAs will maintain active responsibility for the growth of the physical therapy profession and the health of the people it serves.

American Physical Therapy Association. Working operational definitions of Elements of Vision 2020. From the Task Force on Strategic Plan to Achieve Vision 2020. Accessed September 2009 at: [www.apta.org](http://www.apta.org).

The terminology used in the vision sentence/statement relates to the following:<sup>26</sup>

- *Autonomous physical therapy practice environments* include all physical therapy practice settings where PTs accept the responsibility to practice autonomously and collaboratively to provide best practice to the patient/client. Such PT practices are characterized by independent, self-determined, professional judgments and actions.
- *Direct access* means that throughout his or her lifetime, every consumer has the legal right to directly access a PT for the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.

- The *Doctor of Physical Therapy (DPT)* is a clinical doctorate degree (entry-level) that reflects the growth in the body of knowledge and expected responsibilities that a professional PT must master to provide best practice to the consumer. All PTs and PTAs are obligated to engage in the continual acquisition of knowledge, skills, and abilities to advance the science of physical therapy and its role in the delivery of health care.
- *Practitioner of choice* means PTs who personify the elements of the Vision 2020 and are recognized among consumers and other healthcare professionals as the preferred providers for the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health.
- *Evidence-based practice* means access to, and application and integration of evidence to guide clinical decision making to provide best practice for the patient/client. Evidence-based practice includes the integration of best available research, clinical expertise, and patient/client values and circumstances related to patient/client management, practice management, and healthcare policy decision making. Plans for evidence-based practice include enhancing patient/client management and reducing unwarranted variation in the provision of physical therapy services.
- *Professionalism* means that PTs and PTAs consistently demonstrate core values by aspiring to and wisely applying principles of altruism, excellence, caring, ethics, respect, communication, and accountability, and by working together with other professionals to achieve optimal health and wellness in individuals and communities.

## BEYOND VISION 2020

The APTA vision statement adopted in 2013 includes new guiding principles:<sup>25</sup>

- **Identity.** The physical therapy profession will be recognized as the experts in movement systems in practice, education, and research.
- **Quality.** The physical therapy profession will identify, adopt and utilize evidence-based principles in practice, education, and research.
- **Collaboration.** The physical therapy profession will identify and value interprofessional collaboration in order to provide integrated services for society and consumers.

- **Innovation.** The physical therapy profession will develop inventive practices in research, education, and practice to lead health care.
- **Consumer-centricity.** The physical therapy profession will value patient needs as core to all interactions and will create a culture that values the cultures of all people.
- **Access/Equity.** The physical therapy profession will identify and develop creative avenues to reach all people in need of physical therapy care and education.
- **Advocacy.** The physical therapy profession will be an advocate for consumers in research, education, and practice.

### Achieving Direct Access

Direct access means the ability of the public to directly access a PT's services such as physical therapy evaluation, examination, and intervention. Direct access eliminates the patient's need to visit his or her physician to ask for a physician's referral. Licensed PTs are qualified to provide physical therapy services without referrals from physicians. Direct access decreases the cost of health care and does not promote overutilization. The APTA assigned direct access to PTs as a high priority in the Association's federal government affairs activities. In 2005, the Medicare Patient Access to Physical Therapists Act was introduced in the House of Representatives, and its companion bill in the Senate. The Act and the bill recognized the ability of licensed PTs to evaluate, diagnose, and treat Medicare beneficiaries requiring outpatient physical therapy services under Part B of the Medicare program, without a physician referral. In 2014, all 50 states and the District of Columbia passed legislation that allows PTs to evaluate and treat patients without a physician's referral.<sup>27</sup>

### PTA Caucus

In June 2005, the National Assembly of Physical Therapist Assistants was dissolved and the Physical Therapist Assistant (PTA) Caucus was formed. The National Assembly of PTAs was formed in 1998 as the Affiliate Assembly. The PTA Caucus's purpose was to more fully integrate PTA members into the APTA's governance structure and increase PTAs' influence in the Association.<sup>28</sup> The PTA Caucus represents the PTAs' interests, needs, and issues in the APTA governance.<sup>28</sup> The caucus includes a chief delegate and four delegates representing five regions.<sup>28</sup> Additionally, there are 51 PTA Caucus members representing 51 chapters.<sup>28</sup> Each PTA Caucus representative is elected or

selected by his or her state chapter. The PTA Caucus also elects one chief delegate and four delegates (representing five regions) to the APTA's House of Delegates. The PTA Caucus representatives work with their chapter delegates and provide input to the delegates to the HOD and the advisory panel of PTAs. Each delegate has the ability to speak, debate, and make and second motions providing representation in the HOD for a particular region of the country.

## Membership in the American Physical Therapy Association

The APTA is the national organization that represents the profession of physical therapy. Membership in the Association is voluntary. Active members of the Association are PTs, PTAs (also called affiliate members), and PT and PTA students. Other Association members are retired members, honorary members (people who are not PTs or PTAs but who made remarkable contributions to the Association or the health of the public), and Fellow members (called Catherine Worthingham Fellows of the American Physical Therapy Association). The Fellow member is an active member for 15 years who has made notable contributions to the profession. As of 2013, the APTA membership consisted of approximately 88,000 PTs, PTAs, and student members. The APTA includes 51 chapters operating in the United States and its territories. Each chapter offers a variety of events, professional development activities, and other opportunities for members' interaction.

The requirement for membership in the APTA is to be a graduate of an accredited PT or PTA program or to be enrolled in an accredited PT or PTA program. PT or PTA students are welcome as student members of the Association.

The Association describes the following 12 specific benefits for student members:<sup>29</sup>

How Will APTA Membership Jump-Start Your Career?

1. Enjoy significant members-only savings on APTA's products, services, and conferences.
2. Explore new topics and research you won't find in the classroom through podcasts, newsletters, and more.

3. Get solid advice from people who have been in your shoes through APTA's mentoring programs.
4. Find the right job—studies have shown that when they have the option, employers prefer to hire APTA members.
5. Become involved in professional issues and debates by participating in the Student Assembly and student special-interest groups.
6. Stay current through *Guide to Physical Therapist Practice*, podcasts, ArticleSearch, *PT in Motion*, *PTJ Online*, *Student Assembly Pulse*, and other publications.
7. Connect with students, educators, and clinicians now and build lifelong contacts and friendships you can rely on for years.
8. Explore APTA's 18 special-interest sections now and know exactly where your interests lie when you embark on your new career.
9. Build leadership skills and make a difference—take on active volunteer roles in the Student Assembly and your state chapter.
10. Protect your future with APTA-endorsed plans and programs for professional liability, education loans, and more.
11. Save 50% upon graduating when you convert to PT or PTA membership—APTA's graduation gift to you.
12. Do your part to ensure the best possible future for the profession. APTA is the voice of physical therapy, actively representing the profession on Capitol Hill, in state legislatures, and with regulators.

The American Physical Therapy Association. Membership Benefits for Students. The American Physical Therapy Association website. Available at: <http://www.apta.org>. Accessed July 2014.

As of 2013, most members of the APTA were females, with an average age of 44.1 years.<sup>30</sup> Members averaged 18.4 years working as a PT, with the majority of members practicing for more than 31 years.

As of 2013, the APTA's demographic profiles<sup>31</sup> for PTA members indicate that most of the PTAs were female (79 percent). In regard to age, in 2013, the highest percentage (16.4 percent) were between 45 and 49 years old, the second highest (15.7 percent) were between 35 and 39, and the lowest percentage (0.1 percent) were over 65 years of

age.<sup>31</sup> In 2013, 82.3 percent of all PTA members were working full-time, and 14.4 percent were working part-time.<sup>31</sup> In regard to education, in 2013, 60.2 percent of PTAs had associate degrees, 32.5 percent had baccalaureate degrees, 6.1 percent had master's degrees, and 0.5 percent had doctorate degrees (not DPTs or tDPTs).<sup>31</sup>

## THE APTA'S MISSION

The APTA is the principal membership organization that stands for and promotes the profession of physical therapy. Its purpose is to “improve the health and quality of life of individuals in society by advancing physical therapist practice.”<sup>25</sup>

The 2013 Strategic Plan identified four major goals for the APTA.<sup>25</sup>

1. “APTA will better enable physical therapists to consistently use best practice to improve the quality of life of their patients and clients.”<sup>25</sup> The major push for this goal has been the development of the Physical Therapy Outcomes Registry. It will be a location for data that will lead researchers, educators, and practitioners to better outcomes for our patients. In addition, the sections began the process of creating clinical practice guidelines to support practice decisions.
2. “APTA will be the recognized leader in supporting physical therapists in the delivery of patient- and client-centered care across the lifespan.”<sup>25</sup> As leaders and experts in the movement system, the APTA has developed an annual physical therapy exam to be used with patients to identify the health of a person's movement system. In addition, this goal is pushing for more interdisciplinary work for the betterment of patients and society. This goal has created specific tools to assist with health throughout the lifespan by developing education such as FitAfter 50, Fittest Cities for Baby Boomers, and Painless Parenting 101.
3. “APTA will empower physical therapists to demonstrate and promote high standards of professional and intellectual excellence.”<sup>25</sup> In a continued effort to create experts in movement systems, the APTA created Residency/Fellowship Physical Therapist Centralized Application Services to allow applicants to fill out one application form when applying to multiple programs. In addition, the continuation of the American Board of Physical Therapist Specialists shows growth in numbers. The APTA Learning Center has enhanced its offerings to allow for up-to-date learning on a variety of topics.

4. “APTA will be the recognized leader in setting the standards for physical therapy service delivery and establishing and promoting the value of physical therapist practice to all stakeholders.”<sup>25</sup>

The APTA is known as a strong voice in Washington, D.C. politics for physical therapy services and patient advocacy. In addition, the APTA has worked for payment reform and insurance provider education.

## APTA COMPONENTS

The components of the APTA are chapters, sections, and assemblies. The Association has 51 chapters including chapters in the 50 states and the District of Columbia. Membership in a chapter is automatic. Members must belong to the chapter of the state in which they live, work, or attend school (or of an adjacent state if more active participation is possible). Chapters are significant for governance at the state level and for contributing to a national integration of members in the Association. The APTA has 18 sections. They are organized at the national level, providing an opportunity for members with similar areas of interest to meet, discuss issues, and encourage the interests of the respective sections. The sections usually have an annual combined sections meeting in February.

The Association has two assemblies: the PTA Caucus and the Student Assembly. The assemblies are composed of members from the same category and provide means for members to communicate and contribute at the national level to their future governance. One of the important positions expressed in 2004 by the National Assembly for the Physical Therapist Assistants was that the PTA is the only educated individual whom the PT may direct and supervise for providing selected interventions in the delivery of physical therapy services. The PTA Caucus is benefiting from and also reinforcing the PTA role in the APTA. A 2014 meeting identified the need for the APTA to develop a membership value plan specifically for the PTA member.<sup>32</sup>

## THE HOUSE OF DELEGATES AND THE BOARD OF DIRECTORS

The House of Delegates (HOD) is the highest policy-making body of the APTA. It is composed of delegates from all chapters, sections, and assemblies, as well as the members of the board of directors. The HOD is composed of chapter voting delegates; section, assembly, and PTA caucus nonvoting delegates; and consultants. The number

of voting chapter delegates is determined each year based on membership numbers as of June 30. The annual session of the APTA is the meeting of the HOD. It usually takes place every year at the Association’s NEXT Conference and Exposition in June.

The role of the board of directors is to carry out the mandates and policies established by the HOD and to communicate issues to internal and external personnel, committees, and agencies. The board of directors of the APTA is composed of 15 members—6 officers and 9 directors. Members of the board assume office at the close of the HOD at which they were elected. A complete term for a board member is 3 years. Only active members of the APTA in good standing for at least 5 years can serve on the board of directors. No member is allowed to serve more than three complete consecutive terms on the board or more than two complete consecutive terms in the same office. The board meets at least once a year, and the executive committee meets at least twice a year.

The six officers of the APTA are the president, vice president, secretary, treasurer, speaker of the HOD, and vice speaker of the HOD. The president of the APTA presides at all meetings of the board of directors and the executive committee and serves as the official spokesperson of the Association. The president is also an ex officio member of all committees appointed by the board of directors except the ethics and judicial committee. The vice president of the APTA assumes the duties of the president in the absence or incapacitation of the president. In the event of vacancy in the office of president, the vice president will be the president for the unexpired portion of the term. In this situation, the office of the vice president will be vacant. The secretary of the APTA is responsible for keeping the minutes of the proceedings of the HOD, the board of directors, and the executive committee; for making a report in writing to the HOD at each annual session and to the board of directors on request; and for preparing a summary of the proceedings of the HOD for publication. The treasurer of the APTA is responsible for reporting in writing on the financial status of the Association to the HOD and to the board of directors on request. The treasurer also serves as the chair of the finance and audit committee. The speaker of the HOD presides at sessions of the HOD, serves as an officer of the HOD, and is an ex officio member of the reference committee. The vice speaker of the HOD serves as an officer of the HOD and assumes the duties of the speaker of the HOD in the absence or incapacitation

of the speaker. In the event of a vacancy in the office of the speaker of the HOD, the vice speaker succeeds to the office of the speaker for the unexpired term. In this situation, the office of the vice speaker will be vacant.

### APTA'S HEADQUARTERS

The Association's headquarters are in Alexandria, Virginia. The Association's personnel are available online at [www.apta.org](http://www.apta.org) and at the toll-free number (800) 999-2782. The address of the Association is 1111 North Fairfax Street, Alexandria, VA, 22314-1488.



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## Other Organizations Involved with Physical Therapy

### COMMISSION ON ACCREDITATION IN PHYSICAL THERAPY EDUCATION

The **Commission on Accreditation in Physical Therapy Education (CAPTE)** grants specialized accreditation status to qualified entry-level education programs for PTs and PTAs. The commission is a national accrediting agency recognized by the U.S. Department of Education and the Council for Higher Education Accreditation. The APTA and CAPTE work together to ensure that persons entering educational programs for PTs and PTAs receive formal preparation related to current requirements for professional practice. CAPTE accredits professional (entry-level) programs in the United States for the PT at the master's and doctoral degree levels and programs

for the PTA at the associate degree level. CAPTE also accredits two PT education programs in Canada and one in Scotland.

CAPTE states that its mission is “to serve the public by establishing and applying standards that assure quality and continuous improvement in the entry-level preparation of PTs and PTAs, and that reflect the evolving nature of education, research, and practice.”<sup>33</sup> CAPTE consists of three panels: the Physical Therapist Review Panel, Physical Therapist Assistant Review Panel, and Central Panel. Appointment to CAPTE is done through the APTA staff members, who provide the APTA board of directors with a list of all individuals<sup>33</sup> qualified for open positions who consent to serve. CAPTE reviews the list and makes recommendations of those individuals who best meet CAPTE's needs. The board of directors considers the recommendations of CAPTE and makes final decisions<sup>33</sup> for appointments to CAPTE. The term of appointment is 4 years.

### AMERICAN BOARD OF PHYSICAL THERAPY SPECIALTIES

The American Board of Physical Therapy Specialties (ABPTS) is the governing body for certification and recertification of clinical specialists by coordinating and supervising the specialist certification process. The ABPTS is composed of 11 individuals:<sup>34</sup> eight individuals appointed by the ABPTS for 4-year terms, one member of the APTA board of directors (BOD) appointed by the APTA BOD for a 1-year term, one consumer representative appointed by the BOD for a 2-year term, and one tests and measurement expert appointed by the ABPTS for a 2-year term.

The specialist certification program was established in 1978 by the APTA to provide formal recognition for PTs with advanced clinical knowledge, experience, and skills in a special area of practice, and to assist consumers and the healthcare community in identifying these PTs. The APTA describes specialization as a process by which a PT increases his or her professional education and practice and develops greater knowledge and skills related to a particular area of practice. Specialist recertification is a process by which a PT verifies current competence as an advanced practitioner in a specialty area by increasing his or her education and professional growth.

The Specialty Council on Cardiopulmonary Physical Therapy was the first to complete the process, and the

cardiopulmonary specialist certification examination was first administered in 1985. Since then, seven additional specialty areas were established: clinical electrophysiology, geriatrics, neurology, orthopedics, pediatrics, sports, and women's health physical therapy.

The purposes of APTA's Clinical Specialization Program are as follows:<sup>34</sup>

- To contribute to the identification and development of appropriate areas of specialty practice in physical therapy.
- To promote the highest possible level of care for individuals seeking physical therapy services in each specialty area.
- To promote the development of the science and the art underlying each specialty area of practice.
- To provide a reliable and valid method for certification and recertification of individuals who have attained an advanced level of knowledge and skill in each specialty area.
- To help the consumers, the healthcare community, and others in identifying certified clinical specialists in each specialty area.
- To serve as a resource in specialty practice for APTA, the physical therapy profession, and the healthcare community.

## FEDERATION OF STATE BOARDS OF PHYSICAL THERAPY

The Federation of State Boards of Physical Therapy (FSBPT) develops and administers the National Physical Therapy Examination (NPTE)<sup>35</sup> for both PTs and PTAs in 53 jurisdictions: the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands. The purpose of the FSBPT is to protect the public by providing leadership and service that encourage competent and safe physical therapy practice.<sup>35</sup> The exams assess the basic entry-level competence for first-time licensure or registration as a PT or PTA within the 53 jurisdictions. FSBPT's vision<sup>35</sup> is that the organization will achieve a high level of public protection through a strong foundation of laws and regulatory standards in physical therapy, effective tools and systems to assess entry-level and continuing competence, and public and professional awareness of resources for public protection.

For PT and PTA graduates who are candidates to sit for the NPTE, the federation offers a Candidate Handbook

that includes all the necessary information about the exam and exam administration. The handbook can be viewed or downloaded online at [www.fsbpt.org](http://www.fsbpt.org). The federation has been working with the state boards within its jurisdiction toward licensure uniformity supporting one passing score on the NPTE. This uniformity in scores assists PTs and PTAs to work across states.

In 2004, the FSBPT developed for purchase an online Practice Exam and Assessment Tool (PEAT) to help PT and PTA candidates prepare for the NPTE. The online PEAT allows the candidates to take a timed, multiple-choice exam similar to the NPTE and receive feedback on it. When receiving feedback, the candidates have access to the correct answer rationale and the references used for each question. PTA candidates can purchase a PTA PEAT that has two different 200-question exams.

## APTA'S POSITION IN REGARD TO LICENSURE

In regard to licensure, the APTA requires that all PTs and PTAs should be licensed or otherwise regulated in all U.S. jurisdictions. State regulation of PTs and PTAs should require at a minimum graduation from an accredited physical therapy education program (or in the case of an internationally educated PT, an equivalent education) and passing an entry-level competency exam; should provide title protection; and should allow for disciplinary action. In addition, PTs' licensure should include a defined scope of practice. Relative to temporary jurisdictional licensure, the APTA supports the elimination of temporary jurisdictional licensure of PTs or temporary credentialing of PTAs for previously non-U.S.-licensed or non-U.S.-credentialed applicants in all jurisdictions.<sup>32</sup>

## POLITICAL ACTION COMMITTEE

The physical therapy political action committee (PT-PAC) of the APTA is a vital aspect of the Association's success on Capitol Hill in Washington, D.C. PT-PAC ensures that future legislative actions on Capitol Hill are helpful to physical therapy practice. PT and PTA members make donations to the political action committee. The PT-PAC committee uses membership donations to influence legislative and policy issues through lobbying efforts directed toward policy decision makers. The purpose of the PT-PAC is "to

further the legislative aims of APTA.<sup>36</sup> The tasks of the PT-PAC are:<sup>36</sup>

- To raise funds to contribute to campaigns of candidates for national and state office with attention to PTs as candidates for public office.
- To encourage and facilitate APTA member participation in the political process.

### PHYSICAL THERAPY EDUCATION

In regard to PT and PTA education, as of June 11, 2014, there were:<sup>37</sup>

- 224 DPT (Doctor of Physical Therapy) accredited PT education programs
- 1 MS/MPT accredited PT education program (which is changing to DPT)
- 29 developing DPT PT education programs
- 327 PTA accredited PTA education programs
- 47 developing PTA education programs

Outside of the United States there were three PT accredited programs, two in Canada and one in Scotland.

## Discussion Questions

1. List the values of the APTA.
2. A second-year student member of the APTA is developing a presentation to incoming students. What should the student highlight as the purpose and value of becoming a member of the APTA?
3. After reviewing the APTA vision statement and goals, list contributions that PTAs can make to the APTA and profession.
4. Utilizing the APTA webpage, locate the *Information for Prospective Students*. Identify the role and benefits of being a PTA.

## Learning Opportunities

1. Go online at [www.apta.org](http://www.apta.org) and research information about the APTA.
2. Create a brochure identifying the vision, mission, and function of the APTA and the benefits of belonging to the APTA.
3. Participate in a district or chapter/subchapter meeting of the APTA.