Approved: Feb. 23rd, 1993
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Joann Flower at 1:30 p.m. on February 16, 1993 in Room 423-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research Department
William Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Sue Hill, Committee Secretary

Conferees appearing before the committee:
Dr. James Edwards, Kansas Chiropractic Association
Candy Bahner, Director of Physical Therapy program, Washburn University
Carolyn Bloom, Former President of Kansas Physical Therapy Association
Steve Chandler, President of Kansas Physical Therapy Association
Susan Hanrahan, Director of Physical Therapy program, Wichita State University
(provided written testimony only)

Others attending: See attached list

Chairperson Flower called the meeting to order. She made an announcement regarding the pre-admission program, noting an opportunity will be provided for Secretary Whiteman and those Representatives who are interested to discuss the issue. Representative Samuelson is making arrangements for this meeting. Call her office for details.

The Chair recognized Ms. Correll.

Ms. Correll noted, after testimony, and discussion on the issue on Insurance Laws, by Committee, she checked, and finds the physical therapists are not among these named groups of persons who would be covered in the mandate to cover services that could be provided by physicians. Checking a little further, a question had been raised, and perhaps the Committee will wish to address, i.e., to allow a physical therapist to change from a practice that requires referral by a gate-keeper or another provider, to a semi-independent practice. She noted, that would be how this would fit into managed care systems, wherein, whoever is reimbursing, (whether it is in the system itself), or an outside payer, sets parameters by requiring that a gate-keeper, (usually a physician), must refer for all services before they are reimbursed for those services. She noted, it is something that could perhaps be addressed in the bill, if that is the wish of the Committee. It appears that managed care is what is going to be happening more and more, she stated.

Ms. Correll answered questions, i.e., if the Committee wanted to make it clear that under a managed care system, there could be language to require a referral from a gate-keeper. That, then, would make it similar to the Medicare and Medicaid reimbursement.

Chair requested a Staff briefing on HB2278.

Mr. Furse gave a comprehensive explanation of HB2278. He defined the terms spinal manipulation and spinal mobilization. The terms of the bill provide that only the licensees will be allowed to perform spinal manipulation. He further defined the act, i.e., a licensee is not authorized to prescribe or to delegate the spinal manipulation to any other person unless such person is also a licensee. The act would limit the use of spinal mobilization to licensees and registered physical therapists. He explained, basically the language draws the distinction between what a physical therapist may do, as related to spinal mobilization and what a physical therapist may not do, but licensees of the Healing Arts may perform spinal manipulation.

HEARINGS BEGAN ON HB 2278.

Dr. James Edwards, Kansas Chiropractic Association offered hand outs, (Attachment 1-A, 1-B, 1-C. He stated strong support of HB2278) He drew attention to the hand out and detailed the differences between manipulation and mobilization. He noted, spinal manipulation can be harmful when performed improperly or to patients at risk; there are documented cases of fractures, strokes, and even death; athletic trainers, physical therapists, massagers, barbers, and others without proper training are presently doing manipulation. He stated those licensed by the Board of Healing Arts authorized to perform this treatment are, doctors of chiropractic, doctors of medicine, doctors of osteopathy. To protect the public, the Healing Arts Board licensed doctors must carry malpractice insurance and take 50 hours of continuing education each year.

Dr. Edwards detailed the difference between mobilization and manipulation, directing attention to graphs in his hand out. He drew attention to documented cases of vascular injuries as a direct result of spinal manipulation performed by physical therapists, naturopaths, and lay persons. He gave a detailed explanation of a meeting that took place last March between interested parties at the insistence of the Senate leadership. These two groups met trying to reach a compromise on the same issue that is before your Committee again. He noted parties that represented the physical therapists signed off on an agreement, then changed their minds and disagreed to the compromise because of the language, i.e., "non-thrusting". At that point, negotiations broke down, and to this date there is no agreement. He noted the Kansas Chiropractic Association has bent over backwards to make sure that the physical therapists practice rights have not been infringed upon. He stated, if the Physical Therapists Association (KPTA) still object to the term non-thrusting, as it relates to mobilization, then they are in error. He gave a comprehensive explanation of types of manipulation.

Candy Bahner, Director of Physical Therapy at Washburn University offered hand out (Attachment No.2) She opposes HB2278) It is the view of the KPTA, the Chiropractic Association is attempting to monopolize spinal manipulation services in the state and restrain physical therapists from offering spinal manipulation and spinal mobilization services to Kansas consumers. Further, it is the view of KPTA that if legislation is passed concerning manipulation and/or mobilization, it is imperative that physical therapists and physical therapists assistants be included as qualified professionals being allowed to perform these techniques to the spine. KPTA questions the intent of the Chiropractic Association in regard to HB2278.

Susan Hanrahan, Director of Physical Therapy at Washburn State University was unable to attend and sent written testimony for members. See (Attachment No.3).

Carolyn Bloom, practicing physical therapist, and former President of KPTA, offered hand out (Attachment No.4). Ms. Bloom stated the KPTA does not disagree with the Kansas Chiropractic Association, that the public should be protected from untrained persons performing forceful movements to the spinal area, however, KPTA takes a firm stance that physical therapists are trained to perform manipulation and mobilization treatment techniques on patients. She detailed the meeting between KPTA, and Kansas Chiropractor this past March. She noted the current Physical Therapy Act does not prohibit physical therapists from performing the definitions of manipulation and mobilization. These techniques are being taught in current educational programs, and clinical continuing education programs as well. The Physical Therapy Examining Committee and the Kansas Board of Healing Arts have not had a complaint enacted against a physical therapist in Kansas for causing harm to a patient using manipulation techniques. She detailed what physical therapists are allowed to do in their practice of therapy, detailed the terms licensed and registered. She drew attention to an information packet she had sent to each member regarding the issues in HB 2278).

Ms. Bloom returned later to recommend two changes to HB2278, i.e., line 23 (b) to add after "Licensees", "registered physical therapists", and "certified physical therapist assistants".

Mr. Steve Chandler, President of (KPTA), offered hand out, (Attachment No.5), and defined the techniques used by physical therapists, noting a wide range of therapeutic modalities. He noted that joint mobilization or manipulation has a place in the armamentarium of the physical therapist, and has a place among the modalities aimed at reducing muscular skeletal pain and dysfunction and increasing the quality of life for their patients. He drew attention to his hand out, i.e., a copy of a post graduate course and a work sheet. He noted physical therapists have worked hard to achieve the recognition they currently hold.

Chair then opened the meeting for questions from members. Mr. Furse was requested to define the Physical Therapy Practice Act,65-2901, and the Chiropractors Practice Act 65-2871; the differences between licensing and registering was also defined; it was noted it appears there is an attempt to change the status of what is allowed by those persons registered, and it was asked if either of those two groups have addressed this issue in their comments. It was noted,the KPTA did ask to expand their scope of practice to include mobilization at the March meeting.

The Chiropractors agreed to this at the March meeting. It was the view of some members, it is inappropriate to make a licensure act out of a registration act; a detailed explanation was given on hours of education and training and hands-on or contact training; some view spinal manipulation as a skill that cannot be learned in weekend seminars, and believe it takes a great deal of training to learn the skills to provide this procedure.

Lengthy discussion continued regarding the March meeting. Lengthy discussion continued on manipulation procedures. Concerns expressed by the physical therapists and also the chiropractors that HB2113 , HB2278 not be combined. Both groups do not wish these bill be be combined. Discussion was held on the regulating body for the physical therapists. The Board's regulating authority is clearly defined in respect to the physical therapists in HB2438. Concerns by the physical therapists were versed regarding the KPTA not having a representative on the Board of Healing Arts which indicates inequitable representation for the groups being regulated. Further questions on those persons signing off on the compromise in the March meeting regarding the language "non-thrusting".

The Chair made announcements, i.e., reminder of those seeking further information on the pre-assessment program should call Representative Samuelson.

Chair adjourned the meeting at 2:58 p.m.

Note: There is no Attachment No. l-D. This was an error in typing.

The next meeting is scheduled for February 17, 1993.

VISITOR REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-16-93

NAME	ORGANIZATION	ADDRESS
Joe Tafoya	KCA	Topeka
Ron Edwards DC	KCA	Emporia
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Gary Robbins	KCA	Topeka
Larry Buening	Bd of HA	Topeka
Cammie Tedder	Bd of HA	Topeka
Bill Sneed	KSMA	TOPEKA
Diane McDiarmid	SCMHC	Topeka
Frances Kastner	Ks Physical Therapy Ass	Topeka
Candy Bahner, PT	KPTA	Belvue
Steve Chandler P.T	KPTA	Hiawatha
Carolyn Bloom	KPTA	Eudora
Rick Liby	Gehrt & Roberts	Topeka
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Kerry Townsend	KS Hospital Assc	Topeka
Brent Doane	CONCEE CONSULTING	GROUP
HAROLD RIEHM	KHCA	TOPEKA
Robin Lehman	KS Gov. Consulting	Lawrence

A

MANIPULATION FACT SHEET

- Spinal Manipulation can be very harmful when performed improperly or to patients at risk.

- Spinal Manipulation has caused documented cases of fractures, strokes and even death.

- Athletic trainers, physical therapists, massagers, barbers and others without proper training are presently doing manipulation.

- The Kansas State Board of Healing Arts adopted the following resolution: "Only licensees of this Board may perform manipulation of the articulations of the human body." (April 12, 1986)

- Licensees of the Healing Arts Board are doctors of chiropractic, doctors of medicine, and doctors of osteopathy. They are trained in diagnosis and are required to diagnose the patient's condition prior to treatment.

- To protect the public, Healing Arts Board licensed doctors must carry malpractice insurance and take 50 hours of continuing education each year.

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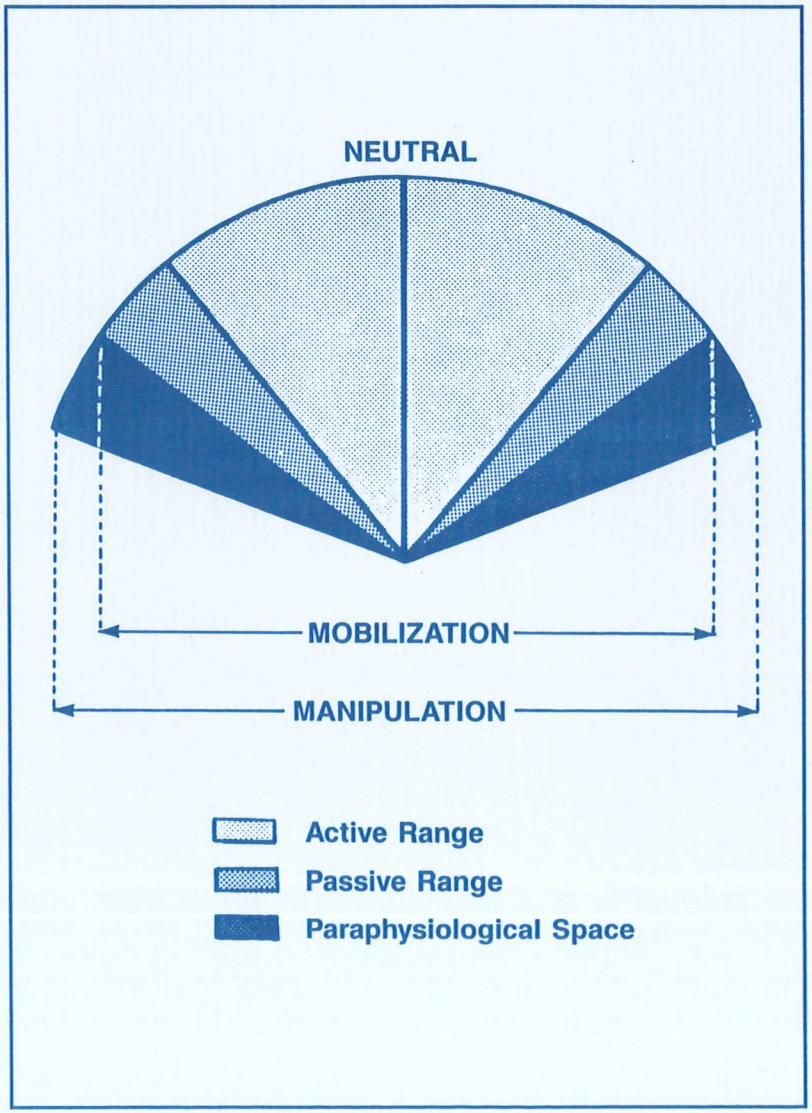
Attm # 1-A

MOBILIZATION AND MANIPULATION
UNDERSTANDING THE DIFFERENCE

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



MOBILIZATION

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

MANIPULATION

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

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COMPARISON OF TRAINING

	Doctor of Chiropractic Logan College of Chiropractic St. Louis, Missouri	**Physical Therapist** University of Kansas Lawrence, Kansas	**Physical Therapist** University of Colorado Boulder, Colorado
Prerequisites:	2 academic years leading to a Bachelor's Degree including required semester hours in the Biological, Physical, and Behavioral Sciences.	Bachelor's Degree including required semester hours in the Biological, Physical, and Behavioral Sciences	Bachelor's Degree "not in physical therapy" including required semester hours in the Biological, Physical, and Behavioral Sciences
Years of Training:	4 years plus 1 year internship	2 years	2 years
Actual Clock Hours of Instruction:	5,490 hours	1,344 hours	1,392 hours
Hours of Instruction in Spinal Manipulation:	1,860 hours	None	None
Hours of Instruction in Diagnosis: (Includes Physical, Clinical, Laboratory, and Radiological Diagnosis)	1,440 hours	None	None

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SPINAL MANIPULATION INJURIES

The following case studies of cerebral vascular injuries were as a direct result of spinal manipulation performed by physical therapists, naturopaths, a kinesitherapist, and a lay person.

Case 1: Parkin et al published a case study of a 23 year old female suffering injury after spinal manipulation by a physical therapist. The manipulation resulted in a left vertebral artery occlusion. The patient had a residual deficit with a Babinski-Nageotte syndrome.

Case 2: Fritz et al reported injury to a 63 year old male after manipulation by a physical therapist. The manipulation resulted in medullary brainstem infarct. The patient required six weeks hospitalization and had residual hemiparesis, dysarthria, and dizziness.

Case 3: Neilsen published a case study of injury to a 44 year old female after manipulation by a physical therapist. Two manipulations were performed which produced balance problems, nausea, vomiting, dysphonia, dis-orientation and memory disturbance. Four years after the manipulation injury, there was no improvement in the patient's symptoms.

Case 4: Schmitt et al reported injury to a 35 year old female by a cervical manipulation by a naturopath. There was a thrombosis of the basilar and left vertebral arteries. Death occurred three hours after the manipulation.

Case 5: Schmitt reports another similar case of a 35 year old female manipulated by a naturopath. There was a dissecting aneurysm of the left vertebral artery with intramural hematoma, which extended into the lower basilar artery. This damaging manipulation also resulted in the death of the patient.

Case 6: Gutmann reported injury to a male after manipulation by a naturopath. Due to a previous fracture of the atlas, subsequent tension to the vertebral artery resulted in fourteen days of blindness with later tunnel vision.

Case 7: Gutmann reports manipulation to a 36 year old male by a naturopath resulted in cerebellar ischemia producing vertigo, nausea, and vomiting for several days. After released from the hospital, the patient made an abrupt movement which again resulted in an episode of the ischemia.

Case 8: Masson et al reports manipulation by a kinesitherapist to a 33 year old female resulted in a Wallenberg Syndrome.

Case 9: Ford et al reported injury to a 37 year old male after cervical manipulation by his wife. There was a thrombosis of the basilar, left posterior inferior cerebellar and left posterior cerebral artery. Death occurred sixty hours after the manipulation.

SOURCE: Allan G. J. Terrett, DipAppSc, BAppSc, GrandDipTertEd, F.A.C.C.S.; Lecturer, Dept. of Diagnostic Sciences; Phillip Institute of Technology; Bundoora, Victoria, Australia; "Vascular Accidents from Cervical Spine Manipulations: Report on 107 Cases," ACA Journal, April 1988.

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B

agreement reached on March, 92

AN ACT relating to persons licensed by state boards; limiting the performance of certain procedures to such persons.

Be it enacted by the Legislature of the State of Kansas:

Section 1. As used in this act:

(a) "Manipulation" means the application of manual or mechanical forces to the human living body's joints and adjacent tissues that produce joint motion beyond the elastic barrier or passive limits of the joint.

(b) "Mobilization" means the application of ~~non-thrusting~~ non-thrusting forces to the human living body's joints and adjacent tissues without exceeding the elastic barrier or passive limits of the joint. with the goal to achieve normal ranges of motion.

(c) "Board" means the state licensing board of the licensee.

(d) "Licensee" means persons licensed to practice medicine and surgery by the state board of healing arts, doctors of chiropractic licensed by the state board of healing arts, ~~and licensed dentists and licensed podiatrists as limited by their scope of practice.~~

Sec. 2. Licensees shall be the only persons allowed to perform manipulation on the human living body in the state of Kansas. A licensee shall not prescribe, authorize or delegate such manipulation to any other person unless such other person is also a licensee. [~~This act does not restrict nor limit the~~ limits use of mobilization to ~~by licensees and registered physical~~ therapists.]

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Sec. 3. Sections 1 to 3, inclusive, and amendments thereto, shall be part of and supplemental to the Kansas healing arts act, the ~~Kansas dental practices act, the Kansas podiatry act~~ and ~~the Kansas physical therapy act.~~ Leave as is

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

3/30/92 [signature] PT

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3/30/92 [signature], PT, Ph.D.

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attm # 1-B
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RATIONAL MANUAL THERAPIES

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Accurate indications, adverse reactions, and dosage schedules for drugs are provided in this book, but it is possible that they may change. The reader is urged to review the package information data of the manufacturers of the medications mentioned.

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power, and velocity are also essential in the management of a back condition. As a result, therapeutic rehabilitation programs are a requisite component of any manipulative therapy treatment for back pain.[5]

The underlying foundation of the rationale for manipulation use is in the detection of motion impairment. Clinical practitioners of manipulation must be able to determine abnormal motion. Although stereoscopic radiography has helped to identify the existence of abnormal spinal motion, few clinical motion tests have been substantiated with regard to reliability and validity. One of the first dilemmas in justifying manipulative therapy is consequently the confirmation of the problem.

A biomechanical problem in spinal motion can interfere with range of motion and/or motion control. The ability of a manipulative therapist is dependent upon an accurate assessment of motion quantitatively and qualitatively. Quantitatively, abnormal motion can be regarded to be either hypomobile—meaning decreased movement—or hypermobile—meaning increased movement. Qualitatively, abnormal motion is defined to mean either resistance or ease to motion. The skill of a manipulator is related to the accurate assessment of motion behavior. Clearly, the type of manipulation therapy chosen for a motion restriction and/or resistance disorder is different than for a motion instability where normal tissue restraints are inadequate.

TYPES OF MANIPULATION

The word manipulation takes on different meanings among health practitioners and lay people. The ambiguity and lack of clear definition of manipulation results in communication problems which ultimately lead to misconceptions. To some, manipulation is the use of a vigorous high-speed manual maneuver which repositions displaced bones into place and results in a pop or crack. To others, manipulation may mean a gentle, refined motion which increases joint motion or soft tissue extensibility. The language of manipulation must be specifically delineated and defined. The following section identifies the various and most common forms of manipulation used. The purpose is to define each manipulation type so that the language of manipulation can be understood and communication among health practitioners enhanced.

An overview of manipulation types is presented in Table 3.1. The first differentiation to make is between general (regional) or specific (localized) manipulation.

General vs Specific Spinal Manipulation

A general spinal manipulation involves a load applied to more than one joint and usually more than one spinal segment. The manipulative pressure is transmitted to a number of joints/segments which have been determined to be hypomobile. Therefore the indication for regional manipulation is in improving motion in an area of the spine which is generally stiff. The problem that complicates general manipulation is the possibility of increasing motion in an unstable joint not detected during the evaluation.

Table 3.1
Types of Manipulation

General (regional)	Specific (localized)
Indirect	Direct
Noncontact	Contact
Soft tissue	Joint
Mobilization (nonthrust)	Manipulation (thrust)
Types of motion application:	Types:
Graded oscillation	Under anesthesia
Progressive loading	General
Sustained loading	Specific
Types of mobilization:	
Joint mobilization	
Soft tissue therapy	
Soft tissue mobilization	
Myofascial release	
Neuromuscular therapy	
PNF	
Muscle energy	
Positional release therapies	
Strain/counterstrain	
Functional or active	
Assistive motion therapy	

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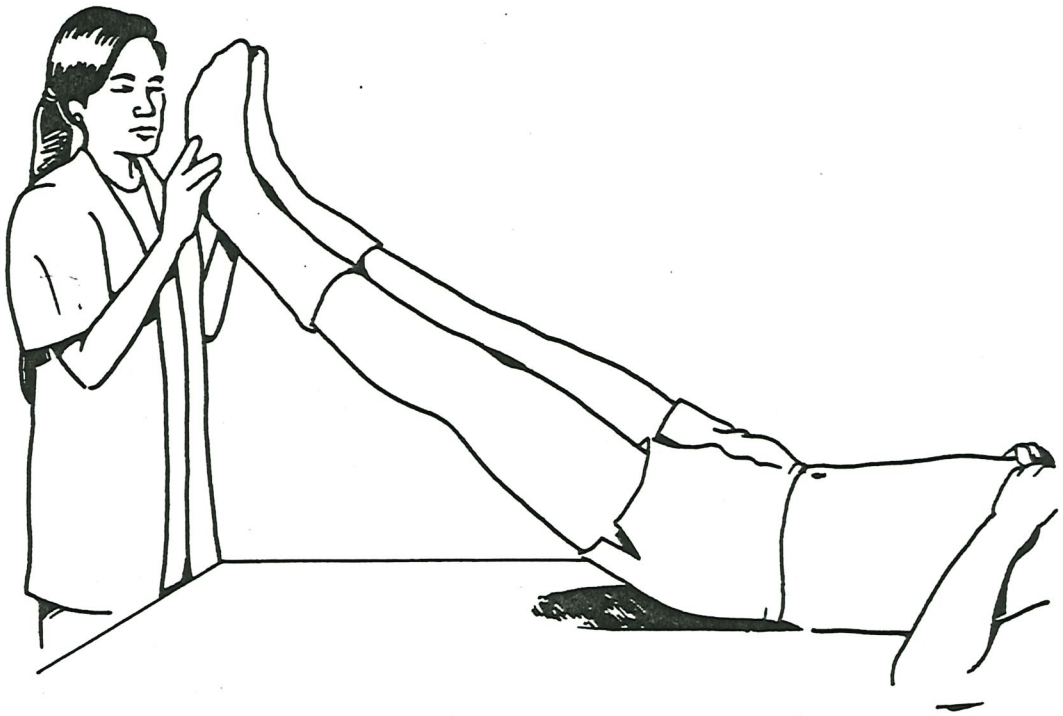

Figure 3.5 Noncontact manipulation to improve lumbo-sacral flexion range of motion.

guarding so that joint manipulation is effective in improving vertebral mobility. In many situations, the force necessary during joint manipulation can be substantially reduced if adequate soft tissue therapy is employed first.

Joint manipulation may or may not involve the use of high-velocity movement. Joint manipulation using a high-velocity, low amplitude movement is also sometimes referred to as *thrust manipulation*. More recently, in osteopathic manual medicine, the term *mobilization with impulse* has been utilized as well. Joint manipulation without thrust or impulse is referred to as joint mobilization.

Joint mobilization involves slower motion activity than manipulation with thrust. The principal objective of joint manipulation (thrust) or joint mobilization (without thrust) is to restore range of motion to a joint with altered motion function. Specifically, joint manipulation may unlock a joint in which motion is blocked or improve range in a restricted joint. Joint manipulation may also improve joint position as well as distribute mechanical stress to a joint more evenly. A repositioning and/or redistribution of stress to a joint often results in a reduction in pain in addition to improving joint motion function.

Joint manipulation can be useful during all stages of joint conditions—acute, subacute, or chronic. The stage of the joint condition, however, determines the type of manipulation employed. As a general rule, joint mobilization is usually more helpful for acute or subacute problems, whereas joint manipulation is usually more effective with chronic conditions, provided that the motion restriction is not too severe. In the case of a considerable joint limitation, soft tissue and joint mobilization should precede joint manipulation. During the immediate period of joint injury where inflammation and swelling exist, joint mobilization and manipulation are generally contraindicated.

In mobilization (nonthrust) three types of motion application can be used: graded os-

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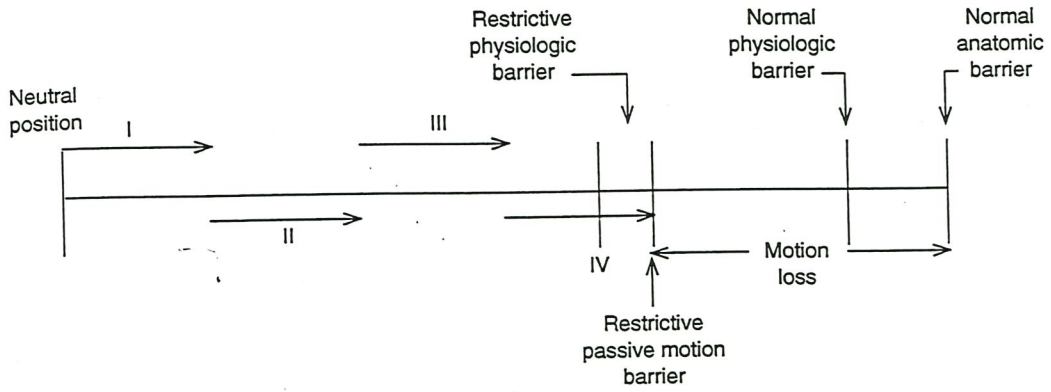

Figure 3.7 Progressive loading ranges and amplitudes. Note grade 1, 2, and 3 progressive loading occur within the available active range of motion. Grade 4 goes beyond the restrictive physiologic barrier and into the passive motion barrier.

plied until the desired motion develops. Maintaining a sustained, uninterrupted load enhances sensory perception to tissue response. In acute, easily provoked conditions, immediate tissue feedback is desired, and therefore sustained loading is recommended. In addition, the viscoelastic properties of adaptively shortened soft tissues can be influenced by the use of sustained loading, particularly if the concept of low load, long duration load application is utilized. Sustained loading mobilization, however, may not be sufficient to mobilize a joint that possesses an intra-articular restraint to motion such as an adhesion or cartilagenous interlocking problem.

JOINT MOBILIZATION

Various types of mobilization have developed within manual therapy and medicine. The importance of defining each type is essential to communication among and between clinical disciplines. Research efforts to substantiate the effect of mobilization on specific conditions requires clear understanding of the definition and language utilized in mobilization. The following section defines and delineates the role of each mobilization type. Further detail is provided in subsequent chapters.

Joint mobilization is a nonthrust manipulation. In osteopathy, joint manipulation performed without impulse is referred to as mobilization or articulatory procedure.[8] Joint mobilization pressures may vary from gentle to vigorous, but are imparted slowly as opposed to thrust or high-velocity manipulation. Since the pressure utilized is slow, controlled, begins gently, and gradually increases, the patient can report about the effect during the time of application. The instantaneous feedback mechanism provides a sense of security for the patient and helps to increase the safety feature of mobilization.

Joint mobilization is performed within the available active and passive physiologic range of the restricted joint. The intent of joint mobilization is to regain normal active range of motion as well as restore passive joint play action. Repositioning of a joint may also come about by joint mobilization, thus improving alignment and stress distribution. Motion recovery, joint realignment, and uniform stress distribution improve joint function which often leads to a reduction in pain. The improvement in joint function increases a joint's adaptive potential to mechanical stress, whether normal or abnormal, and reduces the possibility of re-injury.

SOFT TISSUE THERAPIES

Soft tissue therapies involve manual contacts, pressures, or movements, primarily to myofascial tissues. The purpose of soft tissue directed therapy is to normalize activity status, restore extensibility, and reduce pain. The sci-

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Kansas Physical Therapy Association

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Testimony on House Bill 2278

February 16, 1993

Candy Bahner, PT

Legislative Chair

Kansas Physical Therapy Association

Representative Flower and Members of the House Public Health and Welfare Committee:

I am Candy Bahner, Legislative Chair for the Kansas Physical Therapy Association, a physical therapist and Director of the Physical Therapist Assistant Program at Washburn University.

I am here before you today to speak in opposition of House Bill 2278. By introduction of this bill the Chiropractic Association is attempting to monopolize spinal manipulation services in the state of Kansas as well as restrain duly registered physical therapists and certified physical therapist assistants from competing with chiropractors and other licenses of the state in the delivery of

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Attm #2

spinal manipulation and spinal mobilization services to Kansas consumers. The Chiropractic Association along with Chiropractic Board Members of the State Board of Healing Arts appear to be engaged in a conspiracy to eliminate the Physical Therapy profession from doing procedures they have been trained to do in their educational programs and/or post educational courses. I might also point out that the Physical Therapy Practice Act in Kansas allows physical therapist and physical therapist assistants to do manipulation and mobilization techniques.

Should one profession be allowed to limit the scope of practice of another qualified profession just to prevent competition? I think not. There is no documentation to show justification for suddenly restricting the Physical Therapy profession from being able to perform spinal manipulation and mobilization techniques. Some of the earliest physical therapy writings included the term "manipulation" as techniques performed by physical therapists.

The Kansas Physical Therapy Association asks that you NOT support this legislation as it would restrict the current scope of practice of the Physical Therapy profession in Kansas and deny Kansas consumers the right to continue to seek spinal manipulation and mobilization treatment from a qualified profession, physical therapy.

If any legislation is passed concerning manipulation and/or mobilization we feel it is imperative that physical therapists and

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physical therapists assistants be included as qualified professionals being able to perform manipulation and mobilization techniques to the spine.

The Kansas Physical Therapy Association questions the Chiropractic Association's real intent with this legislation. Why should they feel they need to restrict the Physical Therapy Profession from doing spinal manipulation and mobilization techniques? What proof do they have to substantiate that physical therapist are endangering Kansas consumers. We feel that chiropractors have probably caused more harm to Kansas consumers in performing spinal manipulation techniques than physical therapists. We also find it interesting that each time we introduce legislation to allow for direct access to physical therapy services to Kansas consumers, the Chiropractic Association introduces legislation to define manipulation and mobilization. We question why they need to be in the statues now when we have been teaching and practicing those techniques for several years.

Attached is written testimony from Susan Hanrahan, PT, Director of Wichita State University's Physical Therapist Program which outlines the training PT students receive in manipulation/mobilization techniques. Also in the procedure courses in the Physical therapist Assistant Program at Washburn University we cover manipulation/mobilization techniques. I have also attached copies of continuing education courses for physical therapist and physical therapist assistants on

manipulation/mobilization (manual therapy) techniques.

Again I urge you to oppose this legislation as it restricts a current physical therapy technique allowed by the Kansas Physical Therapy Practice Act and of which we are trained and have been doing for years.

I would be happy to answer any questions you might have.

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AGENDA:

1: CERVICAL SEGMENTS & THORACIC SEGMENTS
Muscle Dysfunction
Identification of Myo-Fascial Trigger Points
Mobilization
Muscle Inquiry Therapy

2: LUMBAR SEGMENTS
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The
Wichita
State University
Department of Physical Therapy

Testimony on HB 2278

Written by:
Susan Hanrahan, PT, PhD
Director, Physical Therapy
The Wichita State University
Wichita, KS 67260-0043
316-689-3604

Madame Chairman and members of the Public Health and Welfare Committee:

This testimony is written in opposition to HB 2278 which limits the ability of registered professionals to perform skills that have been authorized by other legislative statutes. Specifically, Article 29, Section 65-2901 allows physical therapists to evaluate, treat and instruct patients so as to assess, prevent and alleviate physical disability and pain.

The use of manual techniques in the management of patients with musculoskeletal disorders is certainly not new. Physical therapists have been delegated the duty of passive movement for years by most medical doctors (allopathic practitioners) and many osteopathic physicians. Manipulation is simply <u>one form</u> of passive movement. However, physical therapy does not claim beneficial effects on all disease processes when using manipulation as do some esoteric groups (especially from manipulation of the spine). Manipulation is only used by physical therapists for selected orthopedic disorders.

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The master's entry-level professional physical therapy program at The Wichita State University combines the mobilization/ manipulation teachings of John Mennell (doctor of physical medicine), James Cyriax (medical doctor), Robert Magine (French physician), Stanley Paris (New Zealand physical therapist now practicing in the United States), William Sutherland (osteopathic physician), and Geoffrey Maitland (Australian physical therapist) into approximately 100 contact hours of academic instruction and laboratory in the classroom. This does not count the 1000 contact hours that the student spends in clinical practice before they are granted a degree by our university. Thus, physical therapists have both academic and clinical experience in mobilization/manipulation techniques before they graduate.

In spite of the efforts of physicians Mennell, Cyriax and Magine, very few medical physicians practice joint manipulation. Osteopathic physicians, who are skilled in these manual techniques, appear to be using them less due to the shortage of physicians, the sophistication of medical practice and the handling of more serious pathologies. As a result, manipulative treatment may not be available to most patients seeking help from the medical profession other than through physical therapy. It would be unfortunate if this bill excluded the opportunity for patients to receive manipulative treatment in the medical arena--i.e. through MDs, DOs and PTs. Physical therapists are statutorily authorized to perform these techniques across the United States and internationally and have done so since the regulation of the profession. Kansas has experienced no adverse reporting to the Board of Healing Arts or to

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professional liability companies for incompetent acts.

Please oppose HB 2278 or add physical therapists to the list of qualified practitioners. Despite the fact that manipulation is one small portion of the practice of physical therapy, it is an approach that is judiciously utilized in the treatment of our patients and should not be excluded from our armamentarium of treatment.

Please contact me with specific questions. Thank you for your attention to this information.

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Kansas Physical Therapy Association

KPTA

February 16, 1993

Re: H.B. 2278

To: Chairman Flowers and the House Public Health and Welfare Committee Members

I am Carolyn Bloom, past president of the Kansas Physical Therapy Association, past vice president of the Physical Therapy Examining Committee of the Kansas State Board of Healing Arts, and a practicing physical therapist in the Topeka area for 20 years. I wish to give comments on H.B. 2278, an act limiting the performance of certain treatment procedures.

The Kansas Chiropractic Association has described the need of a bill such as this to protect the public from untrained persons, such as athletic trainers, barbers and physical therapists, from performing thrusting manipulations to the spine. The Kansas Physical Therapy Association does not disagree that the public should be protected from untrained persons performing forceful movements to the spinal area. However, the Kansas Physical Therapy Association takes a firm stance that physical therapists are trained to perform manipulation and mobilization treatment techniques on patients in Kansas.

In the spirit of cooperativeness, members of the Kansas Physical Therapy Association met at length with members of the Kansas Chiropractic Association March 30, 1992 to determine definitions of "manipulation" and of "mobilization". Representatives of both Associations were very close to agreement on the language you have before you

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today. However, it is still unclear as to why the physical therapists were then expected to give up the ability to perform one of these treatment techniques after a definition had been written. Chiropractors are very good at the treatment techniques they perform, but so are physical therapists. Why can't both professions continue to provide the services they are currently performing?

The current Physical Therapy Practice Act does not prohibit physical therapists from performing the definitions of manipulation and mobilization. These techniques are currently being taught in schools of physical therapy education across the nation, as well as in clinical continuing education programs. The Physical Therapy Examining Committee and the Kansas State Board of Healing Arts have not had a complaint enacted against a physical therapist in Kansas for causing harm to a patient using manipulation techniques.

Last week you received a packet of information from me regarding this issue. In a letter dated September 18, 1992, Mr. Duane Saunders, an internationally known physical therapist, stated that he taught manipulation and mobilization techniques for nine years in the Wichita State University Physical Therapy Program. For those of us therapists who graduated before manipulation was part of the curriculum, continuing education courses on such manual therapy techniques have been taught since 1974. These courses are 3-5 days in length, are hands on teaching, and are given in up to five incremental levels of complexity. This is a similar method of how physicians, surgeons, and other health care practitioners learn new practice techniques.

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Emotional arguments have been made that all patients must have Xrays and lab. work to rule out spinal tumors prior to treatment of the spine. Since it is widely documented that 95-98% of all low back pain is musculoskeletal that shows normal Xrays, is it cost effective and safe for all patients to be Xrayed? Many physicians currently initiate physical therapy, and do Xrays and further testing upon referral of the patient back to the physician by the therapist if the patient is not making expected progress.

Physical therapists do not make a medical diagnosis, but may use the term physical therapy diagnosis to name the primary dysfunction toward which the physical therapist directs treatment. The therapists base a determination on the physical therapy evaluation which includes a history, musculoskeletal and neurological testing, subjective pain levels and symptoms related to positions and postures, and assessment of the functional status of the patient. We are well aware of certain 'red flags' in the patient's subjective information, that correlated with the objective testing would cause the therapist to refer that patient to a physician. This includes the irretractable pain of cancer.

The terms "licensed" and "registered" health care practitioner is a nomenclature that does not necessarily reflect the degree of professionalism of that practitioner. Physical therapists think of themselves as professionals, who take responsibility for their actions, and legally are responsible for their own actions, with or without a physician's referral. I cannot imagine that a physical therapist would perform a thrusting technique to a patient's spine without first knowing the results of tests and Xrays to rule out bony abnormalities and lesions. Even with the current open physician orders of "evaluate and treat", physical therapists are not causing harm to the public, as stated by the Executive Officer of the Kansas State Board of Healing Arts.

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The Kansas Physical Therapy Association requests two changes to HB 2276. Starting on line 23, (b) Licensees ***and registered physical therapists*** shall be the only persons allowed to perform spinal manipulation on the human living body in the state of Kansas. A licensee shall not perscribe, authorize or delegate such spinal manipulation to any other person unless such other person is also a licensee ***or registered physical therapist.*** This act limits the use of spinal mobilization to licensees, registered physical therapists ***and certified physical therapist assistants.***

Since physical therapists are trained in manipulation techniques, and there have been no reported patient injury from physical therapists performing this technique, allow physical therapists to continue to perform what is currently within their scope of practice. The need to add CPTAs to the list of persons performing spinal mobilization is that spinal traction can fall under this definition.

Do not take away an aspect of the current physical therapy scope of practice, but allow therapists to continue to provide spinal manipulation techniques in Kansas.

Thank you for allowing me to appear before your Committee today. I will be pleased to answer questions.

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Kansas Physical Therapy Association
KPTA

February 16, 1993

Distinguished Chairman & Committee Members:

Physical Therapists have historically treated ailments of the human spine using a wide range of therapeutic modalities including segmental traction and manipulation of the vertebral column to enhance its mobility and range of motion.

Physical therapy from its origin as a profession has focused on postural correction and treatment of patients with scoliosis or other medical conditions affecting the human back and neck, caused by vertebral abnormalities.

Manual and physical techniques rendered to correct such conditions have been integral to the physical therapy profession for the purpose of improving vertebral allignment, increasing intervertebral space and maximizing the musculoskeletal function of the human spine.

As Physical Therapists, we treat the whole physical patient, not just a diagnosis that points to a single structure being at fault such as a lumbar disc. There might also be tight hip joints, weak abdominals, or poor posture. By attending to those things we improve the entire environment in which the diagnosis of the disease exists, and we lessen the chances that the abnormality will again exist.

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The use of joint mobilization or manipulation is not a panacea. It does however, have a place in the armamentarium of the physical therapist. It has a place among the modalities aimed at reducing muscular skeletal pain and dysfunction and increasing our patients quality of life.

Attached to my testimony is a copy of a post graduate course I had taken in 1978 concerning spinal dysfunction. Also is included a copy of an example of a work sheet used during patient evaluation and the importance we place when taking a depth history during our patient's intial exam. Manipulation techniques are just as much a part of physical therapy as chiropractors claim it to be a part of their practice. The methods of manual manipulation may differ from a point of view of scientific explanation as to what they are intended to accomplish, but they are none the less, legitimate to both professions and should not be legislatively excluded from physcial therapy.

Have there been incidents to cause the State Board of Healing Arts to be concerned that physical therapists are performing spinal manipulation or mechanical traction in a less than acceptable manner. I am aware of no such incidents and therapists in Kansas have incorporated forms of manipulation both manual and mechanical in their scope of practice for many years. For what purpose would those restrictions now be placed? Is it the intent of this bill to infringe on a physical therapist's right to practice therapy as defined by our practice act since 1963 and restrict from us a valuable treatment tool which has been used safely over many years in the care of our patients?

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Physical therapists have worked hard to achieve the recognition they currently hold. We trust that the distinguished members of your legislature will act in a fair and responsible manner with regard to our profession as well as to the public's health.

Thank you for allowing me to appear before your committee, I will be happy to answer questions at this time.

Cordially,

Steve Chandler, PT
President
Kansas Physical Therapy Association

HHW
2-16-93
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SPINAL DYSFUNCTION

Etiology and Treatment of Dysfunction

Including

Joint Manipulation

COURSE NOTES

by Stanley V. Paris

Director, Atlanta Back Clinic
Director, Institute of Postgraduate Physical Therapy, Atlanta
Chairman, Orthopaedic Section, American Physical Therapy Association
Consultant, United States Naval Regional Medical Center, Oakland, Ca.

Member, American Physical Therapy Association
Member, New Zealand Society of Physiotherapy
Member, Chartered Society of Physiotherapy
Member, New Zealand Manipulative Therapists Association

Formerly

Lecturer, New Zealand School of Physiotherapy
Consultant, New York University Medical Center
Senior Staff Therapist, Massachusetts General Hospital
Visiting Lecturer, Sargent College, Boston University
Guest Lecturer, United States Army, Academy of Health Sciences
Physiotherapist, New Zealand Olympic and Commonwealth Games Teams

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PHYSICAL THERAPY WORKSHEET

Patient Name _____

SUBJECTIVE:

- Patient's Complaint:
- Nature:
- Behavior:
- Location:
- Onset:
- Course and Duration:
- Previous Treatment:
- Other Medical Problems:

OBJECTIVE:

- General Observation:
- Structural:
- Mobility:
- Neurological:
- Palpation:
- Doctor's Report, Lab & X-ray:

ASSESSMENT:

- Problem List:
- Short Term Goals:
- Long Term Goals:

Plan:

- Treatment:
- Frequency:
- Prognosis:
- Patient Education:
- Follow-up:

Fig. 3-1

Worksheet used to record findings during the evaluation. The physical therapist dictates the intial evaluation (subjective and objective findings), assessment and plan from this worksheet and then it is discarded.

SEQUENCE OF SPINAL EVALUATION A
LUMBAR, MID & LOWER THORACIC SPINE
HISTORY

Standing
Gait
Posture (lateral shift, lordosis
Structural base
Aids and assistive devices
Active SB, FB & BB
Repeated FB and BB
Heel-toe walking
Weight shift test
Active ROM SI joints

Sitting
Posture (lordosis)
Active rotation (overpressure)
Knee, ankle reflex
SLR's
Resisted knee extension
Clear knee
Resisted ankle-toe flexion
Clear ankle
Traction test

Supine
Passive FB (knees to chest)
Repeated passive FB
Long-sitting vs. supine leg length test
SLR's
Check for hip flexor & hamstring tightness
SI spring test
SI mobility test
Sensation
Resisted hip flexion
Clear hip (ROM & compression)
Babinski's test

Side-Lying
Passive FB & Rotation
Palpate ligament and bone

Prone
A-P mobility test
Passive BB
Repeated passive BB
Palpate skin, subcutaneous, muscle, ligament & bone

SEQUENCE OF SPINAL EVALUATION B
CERVICAL & UPPER THORACIC SPINE
HISTORY

Standing
Posture
Aids & assistive devices
Structural base

Sitting
Active ROM neck with over pressure
Resisted cervical muscle tests
Resisted shoulder elevation
Resisted shoulder abduction
Clear shoulder
Resisted elbow flexion
Clear elbow
Resisted wrist extension
Resisted wrist flexion

Sitting cont.
Resisted thumb extension
Resisted finger abduction
Passive forward bend
Passive rotation
Traction test
Palpation
skin, subcutaneous, muscle, ligament, & bone
Thoracic outlet tests (3)

Supine
Cervical mobility test
side bend - rotation
forward bend - side glide
Babinski's test

Fig. 3-2 Sequence of spinal evaluation. A) lumbar, mid and lower thoracic spine B) cervical and upper thoracic spine.

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