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RE: Women's Health Specialization Certification.

I continue to oppose this proposed exam since I first knew of it last September. I have reiterated my position each time I refused to complete the survey.

The issues that concern me include:

- 1) **Premature development given the small numbers of PTs working in this field.** Almost 60% of the respondents surveyed had practiced WHPT for fewer than 10 years and almost half are younger than 34. As Mary Knowles wrote "such health care providers are under-used because of their scarcity". If fewer PTs pursue WH because the exam is perceived as a financial and academic barrier...scarcity will worsen.
- 2) **The huge financial resources required to create the exam could be better used to broaden PT education and community exposure,** and to thus serve more women. I understand that the estimate is more than \$53,000, plus additional interim payments. If that money were given to the 200+ PT schools to ignite interest in WH at the undergraduate level, there would be more WHPTs.
- 3) **Education proceeds in ascending direction.** New knowledge builds on former knowledge. Certification at a post-graduate level should expand established components of PT undergraduate education and practice. WH is far from being an established component of physical therapy education in the USA. Excellent work has been done in that category in Appendices 6 and 7.
- 4) **Priorities that emphasize exposure to a post-graduate specialty instead will set back the fledgling programs of WH in undergraduate PT programs.** The vertical climb to satisfy mainly academics will prevent the lateral movement of PT in WH. This will further marginalize US women in general, and in this profession

in particular. The SOWH has also already strangled exposure by allowing only SOWH-approved courses for the CAPPT.

5). **Narrowing rather than expanding the field of expertise will super-specialize a few while reducing services to the many.** Most PTs are women, and women are the greater consumers of health care services. Therefore it is abysmal that the membership is only around 2300 members since I began the special interest group 30 years ago. Membership in the section does equate with actual clinical involvement in WHPT, as the survey showed.

6) **Most part-time PTs, especially those with young children who can be both role models and therapists to their childbearing clients, will not have the wherewithal to pursue a \$1200 WHCS.** Many of them are unable to afford APTA or SOWH membership: will their status and contributions be "downgraded"?

7) **How many men will choose WHCS?** Only 2 responded to the survey. Several respondents commented that men's health was ignored. Although the opposite gender, those WHPTs with pelvic PT skills treat male pelvic problems; where do they fit in?

The petition lacks polish, as does the SOWH website, with grammatical errors ("very one-on-one", "relative invasive"), misspelling ("Kegal", "pelvis floor dysfunction"), inauthentic unsupported global claims ("*all* health concerns" "dedicated to the improvement of women's health *worldwide*"). The list of journals omitted two key periodicals: *Journal of Obstetrics and Gynecology* and *Birth*. Serious other omissions exist, both historical and current, see below. There is much verbiage to obfuscate (*Obstetrical Dysfunction, orthopedic problems may persist or begin, to completely establish a plan of care (to establish a complete plan of care?) primary examples of skills" (examples of primary skills?) and sex and gender (are they not one and the same?... as are gynecologic or urologic continence)*!

Clear responses to questions are often lacking, confused by non sequiturs and weak associations. Much of the scope of practice includes basic knowledge that should or does already exist in entry level programs. As one respondent commented, "How would a WH specialist equate to a higher level of expertise in body

mechanics, for example?"

For the rest of this document, the original text is in regular type except where I place emphasis with the use of *italics*. My **responses are in bold type**.

The **results of various SOWH surveys**—and the inadequate responses—support my position:

The Workforce Analysis in 2003 studied the amount of percentage of time women's health. The 160 respondents reported the following results for a typical eight-hour day:

- 61% - 5 patients or less
- 34% - 6 to 10 patients
- 4% - 11 to 15 patients
- 1% - 16 to 20 patients p.19

Thus 95% is not full-time.

"These results are potentially skewed downward as there was *no clear definition provided for the respondents as to what constituted a "women's health" patient.*

Was it not critical to establish that? What value is a petition based on "skewed results"?

Estimations of the demand for women's health physical therapy positions in the respondents' local communities of the 164 respondents:

14% - No demand for women's health PT service – enough facilities/therapists offer services

• 35% - Minimal demand – need 1 to 2 more women's health PT's in area to meet demand

• 44% - Moderate demand – need 3 to 4 more women's health PT's in area to meet demand.

8% - Significant demand – no women's health PT services exist in area (p.6)

Only 8% felt there was significant demand for WHPT. Apparently the other communities are served well enough with the existing PT "women's health specialists".

Of the 120 respondents to the recent Practice Analysis, *less than half* (45.8 %)

indicated they were definitely interested in seeking board certification when it is available; 38.3 percent reported they would be interested, but *maybe not for a few years*. **Although the number was higher in a 2003 WorkForce Analysis, this drop in the most recent survey is solid evidence that the proposed WHCS exam is premature and of limited appeal and utility.**

VISIBILITY

NIH...goal of reducing fragmentation in women's health care...Physical therapy is not mentioned in any of these key programs....The profession needs to make its presence, knowledge, and skill base known so that it can impact and contribute to the movement in health care that aims to meet the needs of women. (p. 9)

Yes, the profession does need greater visibility. A few elite specialists will not impact the need for entry-level training and community exposure to WHPT. It will decrease that exposure.

With specialization in women's health physical therapy, our professions will demonstrate its interest and commitment to the female public's needs. (p.9)

Where is the evidence for this statement? This hurdle will limit the number of practitioners.

..."women remain second class citizens in health care settings". (p. 10)

Yes, and a WHCS ivory tower will not address these challenges.

Expand information in undergraduate curricula and address the most common and life-threatening diseases of women for greater visibility within and outside the profession.

Without proper training and credentialing therapists are unlikely to obtain the advanced skills needed to treat those types of conditions. (p.11)

Many training programs exist both within and outside the SOWH.

Credentialing by SOWH alone will limit the exposure, as with the development of a CAPP. Is the SOWH going to do a superior job to the lymphedema and biofeedback certification programs that take place outside the SOWH and the APTA itself? How is this to be financed and promoted? What cross-fertilization will be lost because of the narrow focus on SOWH PT?

...female patients commonly deal with issues of depression (95.3%), Altered body image (73.2%), Domestic violence (62.4%), Anxiety (87.9%), Sexual abuse history

(75.2%), and/or Cancer other than breast or gynecological (66.4%)... (p.11)

Such prevalence demands education at entry level.

To reduce the rate of osteoporosis should have a marked impact on the rate of hip fractures. The women's health physical therapist has knowledge and training in these areas, leading to competency in treating this problematic epidemic.....risk factors include physical inactivity, muscle weakness, balance deficits, and poor health, all of which are issues the women's health physical therapist is prepared to address. (p.12) **This size of this epidemic makes it a concern for every PT. and the risk factors listed above are basic to general PT. This is yet another example of weak association in order to muster specious evidence for creating a WHCS. Nutrition is not mentioned! The UK mandated many years ago that ALL health care providers should impart basic nutritional information. How many PTs know that dairy products are the biggest dietary cause of osteoporosis?**

...fibromyalgia found that 15-25% considered themselves disabled and 26% were receiving at least one form of disability payment. Studies have shown that aerobic exercise, such as swimming and walking, improves muscle fitness and reduces muscle pain and tenderness. Heat and massage may also give short-term relief for the woman suffering with fibromyalgia. Women's health physical therapists have the tools to treat this population and significantly decrease their disability and greatly improve their quality of life. (p.12) **Another weak argument to claim this condition for WHPT.**

Advanced evaluation skills such as pelvic floor examination are required in order to completely establish a plan of care (**sic**). Currently these skills are not *widely* taught in the entry-level programs. (p.12)

Are internal exams taught in ANY undergraduate program?

The profession has an ethical responsibility to the female public to improve and standardize practice. (p.13)

How does standardization of practice make it ethical? The female public would be better served by increased competition and choice.

The *entrance* of advanced practitioners can only enhance and promote any professions' role in improved prevention, diagnosis and treatment of dysfunction. (p.13) **Therein lies the problem! We need *emergence* of advanced**

practitioners from diverse education and experience, not their entrance via a one-day exam!

.....With advanced demonstration of clinical competence the women's health physical therapist will be better prepared to affect women's health and quality of life.

Residency programs and practical courses can better achieve this, not a theoretical exam.

According to the 2003 Workforce Analysis, *only* 7.3% of the 164 respondents reported that no women's health physical therapy services existed in their area. (p.13)

This suggests that WHPT services are already widely established!

The nurses are not trained in rehabilitation techniques related to these dysfunctions. (p.14) **This is an example of professional blindness! What about SUNA, as an example?**

2005 Priorities of the APTA state that physical therapists are universally recognized and promoted as providers of fitness, health promotion, wellness, and risk education programs to enhance quality of life for persons across the life-span. (p.14)

Sadly, they are NOT universally recognized. Chiropractors have more visibility. According to the SOWH survey, only 1% work in wellness! And not one respondent worked in a Wellness and Health facility. (On the SOWH web site, the first two items Keep your body healthy! and Learn about some of the problems that face women as they grow older! have not been developed—there is no link, no information. There are only 2 associations on the web site under "Links".)

...Advanced practice will help our profession to achieve these goals in the area of women's health.(p. 14)

This is a statement without evidence. I would argue that the opposite is true. Prevention programs are broader-based and require fewer skills than treatments.

PREVENTION needs more emphasis; it is listed first in the APTA 2005 Priorities. In this petition, vulvodynia was mentioned with the same frequency (6 times). Yet from 2000 to 2005 there were only 2 published articles

on WHPT and vulvodynia. (p.44). **Obesity is the #1 disease of women and CVD is their greatest killer. In 2003, more than half the deaths, 484,000, were among women. Although women's risk is greatest after menopause and increases with age, heart disease is the No. 1 cause of death in *all women older than 25*. Yet this is not addressed anywhere in the scope of practice! Will programs to prevent these deadly diseases be left to those of the 907 members of the Cardiopulmonary section who are committed to prevention?**

OVERLAP

It would not be in the public's best interest for one area to solely claim a pathology or type of pathology as their territory. (p.15)

Territorial claims are *never* in the public's best interest! Another example is the decision of the SOWH to recognize only its own courses. This limits the entrepreneurial spirit of WHPTs, many of whom I have trained, to go out and teach on their own, and to further their education with courses from allied fields that would enhance their development both professionally, and personally.

There may be other areas of care that the women's health physical therapist shares with other areas of the physical therapy profession, but this *does not mean there is not* a body of knowledge and practice that falls under the umbrella of women's health physical therapy. (p.15)

Double negative—weak argument.

This will continue to be a challenge and all the more reason that there should be recognition of education from other organizations. (p.15)

The CP section and Oncology work with breast cancer yet SOWH claims lymphedema because more women than men suffer from it. There are already certification programs for those who specialize in treating this condition.

The SOWH as well as other organizations provide a number of continuing education courses in this area. The “beginner” courses focus on the basic skills necessary to evaluate and manage pelvic floor and other dysfunctions. Courses are also provided at “intermediate” and “advanced” levels allowing practitioners to develop their manual skills and expand their knowledge base related to disease processes, surgical interventions, and hormonal influences on women's health problems. Given that PTs working in this area often work independently in their

clinical environment, most have also engaged in significant self-study. Advanced degree programs in women's health physical therapy also exist at institutions such as Texas Women's University, Rocky Mountain University, etc. (p.23)

This is excellent and meets the widely-varying needs of a developing group. SOWH efforts should concentrate on recognizing a wide range of such courses offered by different individuals and institutions.

4.4. Discuss in detail how this advanced knowledge differs from the knowledge base required for those specialty areas already recognized by ABPTS. (p.23)

Of note, only 5% of survey respondents were already board certified which supports this knowledge base differing from other established DSPs.

A non-sequitur.

While a review of the different DSPs would indicate there is overlap (pediatrics to geriatrics, orthopedic and neurological disorders, use of clinic electrophysiologic testing), it is also clear that women's health practitioners are dealing *with heretofore, unmet needs of some patients.*

Let's deal with the needs of MOST patients! Male PTs treat more women than men: more WH education must be included in undergraduate programs. For example, pregnant women who go to an orthopedic PT with back pain, will not necessarily seek out a WH specialist, who will be ever-fewer if so defined by WHCS. And, all PTs need address the most prevalent need: to avoid CVD.

No other ABPTS recognized specialty is consistently working with patients who have conditions related to incontinence, pregnancy, menopause, or breast and gynecological cancer. All of these examples would require specialized knowledge beyond entry level. Board certified specialists in other areas seek out practitioners with advanced knowledge and skill sets in women's health as referral sources for their patients who have problems outside their scope of practice. (p.23)

And they are finding them, already! There are existing courses on these topics for those who want to pursue a particular field of interest. Why should those who have taken courses and consider themselves WH specialists (see Cheryl Wisinki's and Lisa Lennan's letterheads in Appendix 13) have to take another exam? Will those PTs be prohibited from calling themselves a WH Specialist in future if they have not taken the exam?

I doubt that those who specialize in pelvic pain, for example, will want to be examined concerning lymphedema.

...the last section of the practice analysis survey indicates that the survey choice “continuing education courses, workshops, seminars, and study groups” had the most influence on development of their women’s health clinical skills as *88% of respondents chose this response.* (p.26)

Continuing Education in WH of all kinds is what the majority wants.

The current continuing education opportunities go from introduction of particular topics to hands-on skill practice. There are several national continuing education programs that offer this advanced training sponsored by private organizations as well as the SOWH of the APTA. In addition, several universities offer post-professional degree programs in the area of women’s health physical therapy and several sites are developing residency programs. (p.26)

Excellent! Residency programs offer the best training. A written exam does not a WH specialist make! Dr. Molly Carnes put the steps in the right order: "A (sic) Section of Women's Health can assure that these issues and other gender-specific issues become and remain a part of training for all physical therapists and develop more in-depth training for these physical therapists who want to acquire special expertise in conditions unique to or more common in women."

OMISSIONS

There are *two* major providers of post entry-level education that are not affiliated with a University: the Section on Women's Health and the Prometheus group. (p. 29)

This is another example of reductionism due to ignorance of the Section's foundation and development.

Over the past 32 years, since introducing WH to PTs (first in 1974 at Simmons College and Boston University) I have taught the longest and the greatest number of participants.

Together in 2005, the SOWH and Prometheus taught fewer than 1000 registrants, in a country where there are an estimated 100,000 PTs! However, this is better than creating a handful of elite specialists.

As the leader in women's health physical therapy education *for over ten years*, the Section on Women’s Health .."**is another example of ignorance and reductionism. The SOWH began as a special interest group and was leading the way already in 1976!**

Stating the truth would enhance the image and mission of the SOWH.

One respondent wrote: "Many women are underserved by the physical therapy community because we do not have specific women's health training in our professional (i.e. entry-level) programs. We need to parallel the medical community in education and competencies in order to keep pace in health care delivery. Women's health specialization should help achieve this goal."

I agree with everything but the last sentence. It is a statement without justification and I believe the opposite to be true: Entry-level programs will be "off the hook" if a WHCS should go forth.

Medical students do OB-GYN rotations, they don't become OB-GYNs without any undergraduate exposure! I cannot imagine a PT, who, for example, having done no orthopedics during undergraduate degree qualification, then seeks certification as a specialist at a post-graduate level.

For my integrity, I have never taught for any vendors. However, I welcome their competition because an open playing field raises the bar for us all. Furthermore, I make available any literature and modalities that any vendor may care to supply at my courses so that registrants may be exposed to the widest range of equipment.

It is in the bringing together of all this knowledge and expertise under one umbrella where a specialty like women's health is born and grows.

Another case where the question was not addressed. (2.7. If other areas of physical therapy practice or other health care professionals are currently meeting the needs, describe how physical therapy specialists can meet these needs more effectively and efficiently.)

This is massaging metaphors! The umbrella is shrinking due to recent SOWH policies of exclusivity.

If the Section is to move forward with authenticity it needs to know whence it came! Firstly, there was no consultation with Annette Iglarsh (a former member of the ABPTS Board), Jane Frahm or myself who were chairs in the beginning years of the SOWH.

The most flagrant example of ignorance is the "Mission Statement" that can

be found in several places: the **Regional Courses Brochure**, the **Petition for Certification** (p. 13 of the "Need Criteria") and on the SOWH web site.

I quote from it, italics mine:

Originally called the Section on Obstetrics and Gynecology, it was founded to serve as a resource for physical therapists interested in the healthcare of women *before, during, and after pregnancy.*

Then follows this grandiose statement:

The scope of practice has now increased to include *all* health concerns of women: incontinence, pelvic/ vaginal pain, prenatal and postpartum musculoskeletal (sic) pain, osteoporosis, rehabilitation following breast surgery, lymphedema, education prevention, wellness and exercise. All females (sic!) across the life span, from the young athlete, the childbearing woman, the menopausal and elderly woman can(should be *may*) receive benefit (*benefits*) from physical therapy.

Firstly, as the original name of the Section suggests, *gynecology* was included at the outset. I arrived from Australia in 1973 with years of experience in private practice and a women's hospital treating incontinence, pelvic pain, post-GYN surgical rehab and having observed all kinds of GYN surgery and births. My experience with modalities such as Kegel's perineometer, diathermy and other forms of electrotherapy, led me to include them in my mission for the Section. This was clearly stated in RC 77 which I compiled to petition the APTA House of Delegates to recognize the Section.

Why does the SOWH want to *diminish* its role and scope by truncating its history?

INTERNATIONAL PERSPECTIVES

In Australia, where PT in WH has been not only integral to the undergraduate curricula, and its practice *endorsed, demanded and reimbursed* for more than a half century, the APA pulled a certification program together only in 2004 and was calling for applicants last year. The UK's WH section was formed in 1948. There are similar numbers of WHPTs in Australia as in the USA, but in Australia more than one-fifth of PTs are WHPTs.

<i>Country</i>	<i>Population</i>	<i>PT Members</i>	<i>WHPTs</i>
USA	296 mill	65,000	2400
UK	60	45,000	7000
Australia	20.5	11,000	2144 (2004)

(There are more PTs practicing who are not members of their national association and special interest groups, but this serves as a perspective on the ratio of WHPTs to total PTS, per country.)

International credibility is already strained for aspects of PT education in the USA, where a PhD can be granted for a survey and a DPT can be obtained online!

SUMMARY

We professionals must be aware that every step of professionalization seeks to limit competition, increase exclusivity, create more barriers to entry, develop more jargon, and fan more desire for monopoly. George Bernard Shaw characterized all professions as "conspiracies against the laity". Regrettable examples are the SOWH's premature move for a WHCS, and the CAPP ("Any continuing education taken for the purpose the CAPP and after January, 2006, must be courses sponsored by the Section on Women's Health".)

Although a certain profession may claim a set of skills, any professional may develop skills that more diverse than her or his profession. This is in the best interest of the public since skills, unlike professions, can be transferred. The SOWH's plan to limit such expansion of skills outside their own parameters for recognition is deeply disturbing.

I founded the SOWH to help women (not just PTs) in the *broadest* number of ways. If the ambitions and hubris of a few would succeed with a WHCS at this point in time many women will be left unserved and many PTs will be frustrated.

Most of the participants in my courses are not SOWH members (yet). The majority is taking their first step into WH and it has always been my mission to ignite their passion in a manner that has both professional and personal value. Inspiration is the key to motivation. We must foster inclusivity instead of exclusivity, so they understand that WH is an evolving field where one can be *more* than "just a PT".

In a few decades, when WH is an integral part of physical therapy training and practice, and *universally recognized and reimbursed*, as in many other countries, then a specialization exam may come in its own time.

The priorities of the SOWH's should be the entry-level curricula and residency programs—on which excellent work has begun—and to increase recognition and reimbursement for *all PTs providing WH services* where specialists or not.

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