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Testimony of Katherine Harris PT, PhD
Chief Delegate, CT Physical Therapy Association

In opposition to

R.B. 1051, An Act Concerning the Practice of Athletic Training

Before the Joint Committee on Public Health
March 2, 2011

Chairperson Gerratana, Chairperson Ritter, Members of the Public Health Committee, my name is Katherine Harris and I am the Chief Delegate of the Connecticut Physical Therapy Association (CPTA) to the American Physical Therapy Association (APTA) House of Delegates and Associate Professor of Physical Therapy at Quinnipiac University**. I am here today to testify in opposition to Raised Bill 1051, An Act Concerning the Practice of Athletic Training.**

The APTA is committed to patient safety and we have strived to improve education for physical therapists so that they are able to function effectively in all clinical settings. As a faculty member at Quinnipiac University in the Physical Therapy Program, my comments will focus on concerns that the Athletic Trainer's didactic and clinical education do not sufficiently prepare them for the patients' settings or standard of supervision considered in this proposal.

One of the tests of the rigors of an educational program is to analyze the standard by which students are evaluated. In comparing the summaries of Athletic Trainer certification content outline and the Physical Therapy licensure content outline, one is struck by the lack of detail and specificity in the athletic trainer's content outline (See attached). The Athletic Trainer certificate content does not suggest the depth of knowledge necessary to operate outside of pre-screened populations without direct supervision, which is suggested in this bill.

As Joan-Alice Taylor testified earlier, written standing orders do not substitute for professional judgment developed through education and clinical experience. The examples that she provided are but a few of those that either present challenging co-morbidities and a need for understanding of pharmacology or the need for a detailed knowledge of pathology/pathophysiology. The Athletic Trainer's classroom and clinical education in no way provides them with the necessary tools to safely and effectively practice in these settings or with complex patients in the out-patient arena.

It is troubling to note that the standard of oversight for Physician Assistants and Registered Nurses, who are better prepared than Athletic Trainers for the challenges of the patients they propose to treat, work under a standard of "supervision, control and responsibility of a licensed physician." This bill proposes allowing Athletic Trainers to treat with merely the "consent and under the direction of" a health care provider. This is a significant reduction with regard to what would be considered an acceptable standard of supervision.

We appreciate the work done by the Connecticut Athletic Trainer's Association with regard to concussion prevention and management. This is a very important issue facing young athletes today; however, in reviewing the bill and their course curriculum, it is inconceivable to me that an Athletic Trainer would be prepared to provide safe and effective care to the wide range of traumatic brain injury patients that would fall under the purview of this bill. If this bill were to pass, would it allow Athletic Trainers the right to "rehabilitate" someone such as Congresswoman Gifford after the tragic shooting in Arizona. I would argue that the education and clinical experience of an Athletic Trainer is insufficient in meeting this challenge.

I'd like to provide you with some concrete examples of the differences between the preparation of a physical therapy student and that of an athletic training student. The purpose of this is not to assert our qualifications, but instead to show that the education and training of Athletic Trainers is not sufficient to address the many needs of the potential patients/clients that fall within the scope of this bill.

The Doctor of Physical Therapy Program at Quinnipiac University requires extensive didactic education in Pathophysiology (9 credits = 135 hours of classroom work), Pharmacology (3 credits = 45 hours of classroom work), Differential Diagnosis (3 credits = 45 hours of classroom work), Introduction to Clinical Decision Making and Advanced Clinical Decision Making (6 credits = 90 hours of classroom work and various onsite clinical education experiences in out-patients, acute care, acute rehabilitation, pediatrics, and sub-acute rehabilitation). This prepares the Physical Therapist to examine the patient/client and determine the impact of various co morbidities, influence of medications, and potential alternative diagnoses that could affect the treatment of the individual. The Athletic Training curriculum does not even begin to address these areas from either a didactic or clinical perspective. And as noted in the testimony of Susan Goszewski, the educational curriculum for Athletic Trainers does not address areas within which this bill would allow them to practice: wellness, ergonomics, and workplace prevention.

As another example, at the University of CT, PT students complete a full semester course (3 credits = 56 classroom/lab hours) that focuses solely on the examination and treatment of the spine, including lecture, lab and online case examples. In addition, the students perform 24 hours of clinical practicum to practice these skills on patients, both at the UConn Health Center and at Nayden Rehabilitation Clinic, an on-campus faculty outpatient clinic.

Nowhere in the UConn Athletic Training Curriculum is there similar course work of this breadth and depth with regard to the treatment of patients with a wide variety of neuromusculoskeletal, cardiopulmonary and medical conditions. The conditions that present themselves in the clinic are often complex and involve co-morbidities that are not covered in the ATC curriculum, including ATC clinical affiliations. In fact, during the ATC clinical rotation at Nayden, Athletic Trainer degree candidates only observe the skills they've learned in class.

Most physical therapists that I know appreciate the work that athletic trainers do a part of the overall health care community. As a matter of fact, many undergraduate athletic training students are being accepted into DPT (Doctor of Physical Therapy) programs at Quinnipiac University, the University of Connecticut, University of Hartford and Sacred Heart University. I would urge the Committee to reject this expansion of the scope of practice for athletic trainers on the grounds that neither their academic preparation nor the standard of supervision proposed put the safety of the patient first.

Thank you for the time today to discuss R. B. 1051. The CPTA and I look forward to working with you throughout the session on this and other health related issues. I'd be more than happy to answer any questions you might have.

Katherine S. Harris, PT, PhD