

Evolution of Neuromusculoskeletal Evaluation and Direct Access Personal Recollections of Army Physical Therapists

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INTRODUCTION

In 2021 the American Physical Therapy Association (APTA) celebrated its centennial and the Army Medical Specialist Corps (AMSC) reached its 75th benchmark in 2022. The AMSC is the Army Medical Department officer corps that includes occupational therapists, physical therapists, dieticians and physician assistants. First, it will be helpful to understand some of the history of the inception of the APTA and the interwoven importance with Army physical therapy.

Before these organizations started, polio epidemics in the late 19th and early 20th centuries established the need for specific therapies to care for these patients. The attention to physical treatments was advanced further with the entry of United States into WW1 in 1917. The necessity to rehabilitate the casualties was recognized by the Army Medical Department which established the specialized training program for physical and occupational therapists, known as “reconstruction aides”.

After the war, groups of reconstruction aides, shortened to “Re- Aides”, wanted to maintain contact and those at Walter Reed General Hospital started considering a national organization. In 1920 Mary McMillan was encouraged by Dr. Harold Corbusier to establish an organization to promote the benefits of physiotherapy to physicians and surgeons. In 1921 McMillian and about 30 other re- aides, as well as LTC Frank Granger, LTC Corbusier (both orthopedists in WW1) and a few other physicians founded the American Women’s Physical Therapeutic Association (AWPTA) (Hazenhyer 1946). That same year its journal, *P.T. Review* was started and in the 1st edition, COL Joel Goldthwait (1921), an Army orthopedist and honorary member of the AWPTA wrote:

The Value of Physio-Therapy as Proved by the War

The war demonstrated, in a manner that probably nothing else could, that even severe injury need not lead to serious disability, provided suitable treatment following the care of the wounds can be given. Good primary surgery and good nursing, of themselves, do not yield results which can be considered satisfactory.

Measures having to do with the early restoration of function in the damaged part are essential, and it is here that the Reconstruction Aide found her great opportunity. With the coming of the first group of Aides to France a new era opened for the hospitals of the A. E. F., and from the first week of their work their

usefulness was so fully demonstrated that the chief problem presented was the finding of a sufficient number of these trained workers.

Not only were many men saved to useful lives, who would otherwise have been crippled, but the principle of physiotherapy and occupational therapy was so definitely established that civil hospitals must provide a staff of such workers, similar to those provided by the Army.

Such a publication as this will do much to preserve the standards and advance the science of the profession. It has the best wishes of all interested in Reconstruction Surgery.

JOEL E. GOLDTHWAIT

He clearly was an advocate for physical therapy as a result of his experiences in the war. In 1921 he could not have foreseen direct access but he may have been a harbinger of direct access to physical therapy.

For more details about the growth of physical therapy in the United States the reader is referred to (Editorial 1960; Moffat 2003; APTA(a) 2020; Rogers 2021). Additional history about the reconstruction aides and the establishment of the Women's Medical Specialist Corps which became the AMSC is available at Hartwick 1993; McDaniel; Vogel; Vogel and Gearin at the AMEDD Center of History and Heritage.

The purpose of this document is to celebrate the aforementioned anniversaries and capture the experiences of US Army physical therapists involved in taking on more independent roles to evaluate and treat patients without a physician's referral. This mainly occurred because of the shortage of doctors, especially orthopedists, during the Vietnam War which led to neuromusculoskeletal evaluation in the Army (Greathouse et al 1994) and direct access in civilian physical therapy. This compilation of oral histories and reminiscences hopefully will preserve some of the names and circumstances of the persons who enabled this gargantuan step for the physical therapy profession and our patients.

It is important to understand that changes were occurring in health care. Due to advancing science, limited medical specialization for physicians started in the 19th century (Weisz 2003). More than 100 years later an impending shortage of doctors was recognized in the 1960s (Editorial 1962, Weiner 2002) which may have contributed to the expansion of physician extenders. The first program for nurse practitioners was started in 1965 (AANP) and for physician assistants in 1967 (AAPA). In 1966 MAJ Barbara Dickinson Gray, the 1st Army PT assigned to a combat zone, noted that physical therapy “. . .received full status as a medical team member . . . “ (Lowery 2015). She served in the 44th Medical Brigade at Long Binh and also was consultant to the 17th Field Hospital in Saigon (Lowery 2015).

Most but not all of the following personal reports were based on telephone interviews; some were extracted from other materials. The military ranks vary depending on the time of the report, but each officer is listed with the rank at the end of service. Many of these reports are based on experiences more than one half a century ago. There are some incongruities and limited abilities to establish exactness of all of the information. Nevertheless, this is a written collection of the persons who were there before and during the Vietnam War, the post war era and the 21st century Middle East conflicts. It offers a view of the progression of Army PTs to being key members in the AMEDD mission to conserve the fighting strength.

Abbreviations:

AMC: Army Medical Center
AMEDD: Army Medical Department
AMSC: Army Medical Specialist Corps
ANG: Army National Guard
BAMC: Brooke Army Medical Center
BG: Brigadier General
CPT: Captain
CAPT: Captain
CONUS: Continental United States
DO: Doctor of Osteopathy
ER: Emergency Room
IED: Improvised Explosive Device
IMA: Individual Mobilization Augmentee
JAG: Judge Advocate General
LBP: low back pain
MAMC: Madigan Army Medical Center
MAJ: Major
MBA: Master's of Business Administration
MFSS: Medical Field Service School
MG: Major General
NMS: Neuromusculoskeletal
NMSE: Neuromusculoskeletal Evaluation
OT: Occupational Therapy
PCS: Permanent Change of Station
POW: Prisoner of War
PTSD: Post Traumatic Stress Disorder
ROTC: Reserve Officers Training Corps
SCI: Spinal Cord Injury
SGT: Sergeant
SP: Specialist Corps, short for AMSC
SHAPE: Supreme Headquarters Allied Powers Europe
TMC: Troop Medical Clinic
TBI: Traumatic Brain Injury
USAR: United States Army Reserves
USPHS: US Public Health Service
WRAMC: Walter Reed Army Medical Center

PERSONAL EXPERIENCES OF ARMY PHYSICAL THERAPISTS

1LT Myrl Jean Hughes

Editor's note: this material was extracted from Curator (2021).

In an interview, dated 10 SEP 2021, LT Hughes indicated that she studied pre-med at the University of Minnesota's junior college in Hibbing, MN. Knowing her parents could not continue her college education, she chose to attend the US Army-Mayo Clinic course for physical therapists in 1942 after which she spent 6 months at US Army Nichols General Hospital in Louisville, KY.

An Army policy did not permit women to serve overseas until age 21 years, three days after her 1 JAN birthday, she was ordered to New Guinea. The trip to Australia took 2 weeks due to evasion maneuvers for submarines. She was assigned to the 334th Station Hospital which had been built by the patients in Hollandia, New Guinea. She served from 1943-1946.

Years later, she mused that she was an Army PT when the physical therapy profession was born and since then physical therapy clinics had advanced greatly. She noted that in her day, "heat, massage and exercise" were what she offered. We ". . . weren't allowed to do anything on our own. Now they get advanced degrees and can do anything they like" (Curator, 2021)

1LT Bette Horstman

I attended and graduated from the University of Michigan in 1943 and from there went to the physical therapy school at the Mayo Clinic in Rochester, Minnesota. After graduation in 1944, I enlisted in the Army Medical Service Corps although we were under the command of the Nursing Corps.

We spent about 3 months at Brooke General Hospital where we were taught specialized care for persons with amputations and burns which was invaluable in the Pacific Theater. This was followed with further training at Harmon General Hospital after which we were sent to FT Lewis, WA. At Lewis we were trained to use a rifle, do the low crawl and use a gas mask. I received my promotion to 2LT.

From Lewis, I shipped over to Hawaii, and I got very seasick enroute. I spent time at FT Shafter and Tripler General Hospital where I treated Italian prisoners of war – they were not motivated.

Editor's note: In 1997, I was an IMA historian at FT Shafter and learned that outside the Pineapple Pentagon, the Italians built a fountain like in their home country but no one knew if it ever worked. The Pineapple Pentagon was built in less than three months in 1943-44 and housed the US Army Pacific Command and continues as the US Army Pacific Command. Continuing with Bette Horstman's comments...

After about six weeks we were transported by plane to be closer to the war. Our 1st stop after midnight was Johnson Atoll, 716 nautical miles southwest of Honolulu, and this was for us to eat food. The place was filled with soldiers which I learned was a reality of the war. They had not seen an American woman for months. After eating we re-boarded and flew to Guam and a day later I arrived on Saipan. I was assigned to the 22nd Station Hospital where I treated patients with sprains, fractures and burns. The major trauma cases were sent to the General Hospitals on Saipan, *(editor's note, most likely this was the 39th General Hospital that had relocated from Auckland NZ to Saipan or the 148th General Hospital. There was still active fighting ongoing on Saipan and many Japanese were living in caves and would make raids to American facilities to steal food).*

Being under the nursing chain of command, was difficult because rehabilitation was not identical to nursing. I finally stood my ground and was placed under the command of a physician and had no problem. I still followed orders but felt like I had a lot of freedom in decision making for the care of my patients.



1LT Bette Horstman in front of the PT Clinic Saipan 1945

LTC Priscilla Katherine Gilchrist

Editor's note: this material was extracted from Lowery (2015) and most unfortunately, LTC Gilchrist is deceased.

LTC Gilchrist had a distinctive career, having provided physical therapy to patients in 3 wars as well as in peace time. She graduated from the University of New Hampshire where she studied physical therapy and English. She soon joined the Army and treated wounded personnel from the Battle of the Bulge in WW2.

She left the Army in 1948 but was “invited back. I missed it”. She was assigned to the 1st Station Hospital, Quan Su and then to the 382nd Hospital in Ascom City, both in Korea.

She stayed in the Army and served in CONUS and West Germany. In 1968, she arrived in Vietnam during the Tet Offensive and was stationed at the 3rd Field Hospital in Saigon. It was her impression, the wounds in those she treated were worse than the previous 2 wars because the more damaging weaponry.

In Vietnam she was the Chief of Staff for the Physical Therapy Clinics and was consultant to the Surgeon General. This required her to travel by helicopter to the various PT clinics. She did work in triage.

COL Rita C. Minogue

Editor's note. This information was extracted from Lowery (2015) and most unfortunately, she is deceased and searching for further information was fruitless.

1LT Minogue served during WW2 after which she left the military. She was recalled during the Korean War, and during the Vietnam War she treated patients at the 6th Convalescent Hospital at Cam Ranh Bay. She retired as a colonel and served in 3 wars, like LTC Gilchrist.

COL Virginia Metcalf

I graduated from Northwest State College in Louisiana with a degree in Physical Education and Recreation in 1953 and entered the Army to attend PT School at the Medical Field Service School (MFSS), at FT Sam Houston TX. This was 7 months of intense didactic training which was followed by 5 months of clinical experience at one of the large Army hospitals, Brooke, Walter Reed or Fitzsimmons.

My first duty assignment in 1954 was at Walter Reed General Hospital. The Chief of PT was MAJ Louise Christman who served during WW2. She was at FT Shafter, HI when the Japanese attacked Pearl Harbor and eventually went on to serve in the Marshall Islands.

MAJ Christman was an excellent clinical educator which I greatly appreciated because of our very limited clinical experience at MFSS. At Walter Reed, I had the opportunity to work with enlisted male physical therapists, including Sam Feitelberg. At that time we were the Women's Medical Specialist Corps. When I received orders in 1957 to PCS to Tripler General Hospital, MAJ Christman had a wonderful luau to introduce me to Hawaii. There, I

treated members of the Army, Navy and Air Force and their dependents, some who had polio.

My next assignment was to FT Sill, OK after which I attended a graduate rehabilitation course at Rancho Los Amigos Hospital. Hazel Adkins was an excellent program director. Jacquelin Perry MD, a graduate of the PT program at Walter Reed during WWII was there as was Marilyn Lister, eventual Editor of *Physical Therapy*. When at Rancho, I started graduate studies and earned my MS, PT degree from the University of Southern California. There I learned from Roxie Morris, Jean Ayres, Margaret Rood, Frankie Grover, Mary Bennet and others- all top level educators.

My next duty station was Brooke General Hospital where I treated soldiers injured in Vietnam and we were engaged with clinical education for students from MFSS. Next, 1967, I PCS'd to 2nd General Hospital at Landstuhl, West Germany. I had the opportunity to learn from the German PTs, "Krankengymnastiks" and I was promoted to LTC.

I returned to the USA and served as Chief of PT at Letterman Army Medical Center. We treated a lot of casualties and POWs. We also had students from Stanford University and University of San Francisco.

My next duty station was Brooke General Hospital. The Chief of Physical Medicine and Rehabilitation (PMR) was COL Roth who had been a surgeon during the Korean War. Due to injuries he switched specialties to PMR. He was a major proponent of PT! Because Brooke provided support to all the regional Army hospitals, he traveled to these out-lying facilities. When CPT Jane Sweeney was assigned to Brooke, he was delighted because she brought pediatric PT skills to Brooke and to the region. This expanded to neo-natal follow-ups and helped to establish the Exceptional Family Member Program.

Army Physical Therapy evolved from early in my career starting when PM and R and Orthopedic surgeons referred directly to PT with PM and R screening all the written referrals to PT. As you know this process gradually changed with physician shortages in the Viet Nam era and as PTs demonstrated increasing competencies and knowledge with continuing academic and clinical specialty education opportunities.

My recollection of musculoskeletal screening of LBP patients in the Troop clinics began in the early 1960s at Ft Sill with a pilot project CPT Robert "Bob" Doctor initiated. In 1964, MAJ Jane Gierhart was assigned to Ft Sill by LTC Marilyn Anderson, Chief of Physical Therapy, Surgeon General's Office, to formally develop the program.

During my time as Chief of the Physical Section of the AMSC 1979-1983, I felt that that we had regulations in place to support the Army Physical Therapy advancement to the Neuromusculoskeletal Evaluation process.

All of these factors, in my mind, have contributed to the evolution of the PT profession. Perhaps the most significant factor has been the changing of the U.S. Army Entry Level Educational Programs for PTs beginning with the hospital based PT programs

in WWII, then the Consolidated Medical Field Service School (MFSS) PT Program at FT San Houston, TX. This advanced to the Army PT Education Program at the Academy of Health Sciences and now the US Army-Baylor University Doctoral Program in Physical Therapy. Progressing from Certificate to Doctorate over all those years of educational growth and development through thick and thin has been an outstanding accomplishment of all the staffs and faculties throughout the years.

For further details of COL Metcalf's Army career see Prime Timers 2019.

1LT Delores “Dee” Martin

I graduated from the Army Physical Therapy Academy in 1961. I met my soon to be husband there. An Army aviator, he was transferred to FT Ord, CA and I was able to get reassigned there in 1962.

Both at Brooke Army Medical Center where I served upon graduation and later at Ft Ord, I recall always getting an order for physical therapy from a physician. Nonetheless, we always evaluated our patients to determine the needed physical therapy interventions.

Prior to attending physical therapy school, I graduated from the Women's College of the University of North Carolina (UNC), Greensboro. As a student in college, I learned the importance of research and I recall studying bicep muscle function; thus, I had a research background.

I was attracted to the Army because there were two persons ahead of me at UNC who went to Ft Sam Houston to become physical therapists.

As was the norm at that time, I was required to leave active duty in 1962 because I was pregnant. I taught in public schools for 25 years and in junior colleges. Toward the end of that time, I was asked to provide pediatric physical therapy in schools and this allowed me to work with the County Health Department and in home health. Direct Access was not typical in these settings but I evaluated each of my patients and I had great latitude in decision making.

The Martin Army Hospital at FT Benning, GA is named for my father-in law Major General Joseph I. Martin, MC who served in Europe in WW2.

LTC Barbara C. Reid

Editor's note: This information was extracted from Lowery (2015) and searching for further information was fruitless

CPT Reid had served 18 months at the 106th General Hospital in Japan before volunteering to PCS to the 67th Evacuation Hospital at Qui Nhon, Vietnam. She arrived during the Tet offensive. Her first night, she was awakened by sirens of a Red Alert meaning there were incoming rounds and the perimeter had been breached. This became a not uncommon event. Prior to Vietnam, PTs were not assigned to combat zones.

We worked 12 hour-days with 1 day off a week. Equipment was scarce and thus much of it was homemade from metal scraps and lead shot. “The trauma and injuries were horrific . . .” She treated POWs and civilians including post-polio patients who had never been treated – something new from which she learned muscle substitution patterns.

She was awarded a Bronze Star.

LTC Reid also published 3 articles in *Physical Therapy*.

LTC Aida Nancy Sanchez

Because of her stellar Army career, this report is written by the editor from other resources. She is deceased. See Aida Nancy Sanchez; Lowery 2015.

LTC Sanchez joined the US Army in 1952 from her native home in Puerto Rico and graduated from the Army Physical Therapy School. She served at Tripler Army Medical Center when Cambodian President Lon Nol was treated there for a stroke. She worked with Chief of Physical Medicine, Dr. Dick Matterson to develop a rehabilitation plan for President Lon Nol. On 25 December of 1970 she arrived in Vietnam to open the 1st PT clinic in the 95th evacuation hospital near DaNang, Vietnam. It was in a Quonset hut. She treated military members and civilians and she also involved with triage and emergency nursing. (Military Women’s Memorial, Aida Nancy Sanchez)

During her time in Vietnam, she was told that she needed civilian clothes and she would be going on a secret mission. She was taken to Cambodia to treat President Lon Nol at his palace. At that time she was the only American allowed in the palace and compound. Because of this she was asked to identify others who were with the President because the US State Department suspected communist infiltration into the Lon Nol inner circles. She was upset that she was asked to treat the Cambodian President and spy for the US government.

She returned to Vietnam and 2 weeks later she was back in Cambodia. She enjoyed a situation when President Lon Nol was starting ambulation and needed a cane. The next time she returned to Cambodia she was directed to a large room in the palace and she found canes hanging from the ceiling which were given to him from countries all over the world. She laughed as she wondered if her mission was so secret why so many countries knew to send him a cane? She also noted that even *Newsweek* reported about President Lon Nol’s “. . . illness and how he was improving.” (Lowery 2015).

She recalled approaching a very pregnant female POW to treat her, the woman grabbed my neck to choke me. A special forces sergeant rushed to help me but we could not get her hands off of my neck. He finally slapped her.

COL Mary “Sue” Ozburn

This is written by the editor by compiling comments from the other contributors and information gathered from other resources. COL Ozburn is deceased but her name and influence was mentioned by several; thus her legacy should not be lost among the oral histories of others.

COL Mary “Sue” Ozburn served 30 years in the Army, including a tour in Vietnam at the 36th Evacuation Hospital, Vung Tau. After graduating from the Army Baylor Program, 1LT Gail Deyle served under COL Ozburn at FT Jackson. He stated that she was “. . . a true pioneer and advocate for direct access. “ In a power point presentation, COL Deyle notes that COL Ozburn was highly decorated and “On fire with passion for her vision of an advanced competency role for physical therapists. She formed and mentored a team, advocated our competency, and demanded our best.” COL Jean Bryan Coe agrees.

COL Nancy Henderson concurred, writing, “. . . COL Oz was a was very strong advocate for physical therapists being the initial evaluators for musculoskeletal problems.” COL Henderson indicated that COL Oz practiced direct access in Vietnam and at FT Jackson studied overuse injuries in the basic trainees. She was able to make modifications to the training procedures and reduce injuries.

MAJ Sue Ozburn in Vietnam



LTC Rebecca Harrison Shumate (Richardson)

Editor's note: This information was extracted from Lowery (2015) and searching for further information was fruitless.

1LT Shumate arrived in Vietnam in 1972 and served at the 3rd Field Hospital which was renamed the US Army Hospital Saigon. She treated many patients that were sent to larger American military hospitals after being stabilized. She provided out-patient care and treated allied service members and civilians. She spent weekends treating Vietnamese polio patients at orphanages and coordinated care for them with the National Rehabilitation Institute of Saigon. She also volunteered to teach English at the Seventh Day Adventist Nursing School in Saigon.

COL Duane Saunders

In 1961 I completed ROTC, graduated from Kansas State University and was commissioned in the US Army Artillery. I was deferred so that I could attend Physical Therapy School at the

Mayo Clinic. After graduating in 1963, I returned to active duty as an Artillery Officer spending most of my time at Ft Sill, Oklahoma.

I recall that as an Artillery Officer, I tried to get a branch transfer to the AMSC to become a physical therapist but was denied. The rationale offered was that male therapists could not treat female patients; thus I could not be assigned to a 1-therapist clinic. A 2-therapist clinic was also ruled out because each person would have 30 days of leave. With this rule there weren't many male physical therapist positions.

After completing two years of active duty in the artillery, I still owed 6 ½ years in US Army Reserves. I found a Reserve Field Hospital and got a branch transfer to the AMSC. I was assigned to a general hospital in Kansas City but lived 200 miles away in Great Bend, Kansas. The General Hospital Command in Kansas City permitted several of us to train with a local Reserve Unit in Great Bend.

I attended a nine-day course at Ft Hood Texas that was taught by Stanley Paris and I met Major David Greathouse. He was stationed at Ft Riley, Kansas and the two of us worked together to organize an orthopedic study group in Kansas, we eventually taught a 2 day musculoskeletal course at several places.

Later, Major Greathouse was assigned to Ft Sam Houston where he became the Chief of the Physical Therapy program. He asked me to become his counterpart in the Reserves.

As my 20 years of service was approaching, COL Greathouse was promoted to Chief of the Physical Therapy Section of the AMSC. Again, he asked me to follow along as the Chief of the Reserve component.

My earlier time in the reserves included various units and I recall an assignment at Ft Bliss. The Chief of the Physical Therapy Clinic knew that I had been teaching Musculoskeletal screening but she told me that she treats all necks and backs. She assigned me to the 100 plus bed ICU where I treated lots of patients with severe spasms and no direct access patients.

Because of my service time in the Army, upon retirement, I always advocated for civilian therapists to strive for independent practice. I believe that Kansas passed direct access legislation earlier than most other states and I attribute that to the orthopedic study group that COL David Greathouse and I started years earlier.

Editorial Note:

I, Tim Kauffman, enjoy recalling that after leaving active duty in 1977, I stayed in the Active Reserves and when I was ordered to my 2 weeks of reserve duty, I was informed that I could not evaluate and treat a patient without a physician's referral because I had not taken the required *Neuromusculoskeletal Assessment for Physical Therapy Officers Course* taught by COL Duane Saunders. It did not matter that in 1973 at Madigan Army Medical Center and later at the US Army 5th General Hospital, Bad Cannstatt (Stuttgart), West Germany I was permitted to evaluate and treat persons with low back pain without a physician's referral. I completed COL Saunders'

excellent training in 1983 and was certified to perform direct access. Although I was frustrated about this requisite, I completely understood and agreed with this credentialing process because it was an expansion of evaluating patients with other complaints and injuries.

LTC Robert “Bob” Ashley

In high school, I was a three-year member of ROTC and served as the colonel my final year. After graduation, I joined the Iowa National Guard and served for 6 years and made the rank of SP5 (Specialist 5th Class). These years helped with pay increases as well as some for retirement.

I attended physical therapy school in 1960 at Kansas University Medical School and started a private practice in Norfolk, Nebraska. Eventually, my practice moved to Omaha, Nebraska and Council Bluffs, Iowa. I provided in-patient and out-patient care and felt that I had direct access in these settings because there were no other PTs available. I was teaching the physicians what PT is. They would call me and ask questions about physical therapy for their patients. Additionally, I attended hospital staff meetings and worked with the Iowa Department of Health. Incidentally, Iowa at that time did not have a licensure law so I received the first one by reciprocity as well as having licensure in Nebraska.

Having been very busy with work and almost no vacation time, I saw a photo in a PT journal of an injured GI being helped by a physical therapist. I started thinking about joining the Air Force or Navy but found COL Joan Graziano who was recruiting for the Army Medical Specialist Corps. I received my direct commission in May 1969 as a Captain.

After MFSS at FT Sam Houston, I was assigned to Fitzsimmons Army Hospital, where I found that “direct access” was common. I worked with a lot of patients with amputations and prostheses and I coordinated their care. We started a program for adaptive snow skiing and horseback riding and scuba diving. One Wednesday I was skiing and on Saturday I was enroute to Vietnam, May 1970.

I served at the 6th Convalescent Center at Cam Ranh Bay on the South China Sea from April 1970 to 1971 for 364 days – a 1 day early out. Our focus was reconditioning to enable the soldiers to return to their duty stations. The exercising was categorized into 3 groups, “mild”, “moderate” or “heavy duty”, dependent upon the injury. There were daily outdoor exercises, calisthenics and a 1 mile track. There were usually four to five 91Js (the MOS for PT enlisted personal) working with us and our patients. There were only 2 physicians for patient and staff care so nearly everything was “direct access”. We treated a lot of sprains, strains and minor burns.

There was a sapper attack in August 1969 and thus when I had AOD, I was armed with a 45 caliber pistol or a carbine. Patients who were nearly ready to return to duty served as guards for the compound that was also protected by a tower, barb wire and revetments. The Korean unit next to us also had guards but one was found sleeping on duty and was shot by his officers.

My roommates were a dentist and a Chinook helicopter pilot. I had the opportunity to fly several times. I had additional duty responsibilities as the billeting officer and I paid the mamasans for laundry work. Our staff would occasionally go to different Vietnamese villages for MEDCAP assistance. I enjoyed my time and it was a deep honor to be awarded a Bronze Star Medal for my work in Vietnam.

I returned to the States and spent 3 years at West Point, NY. MAJ John Swanson served with me. The doctors attended “sick call” but many had direct commissions and did not have Officer Basic Training so teaching them military protocol was one of our responsibilities. Officers were always saluted by the cadets. Most of our patients were cadets who had sprains/strains and we were practicing “direct access”.

We did some research and published a paper in *Clin Orthop Relat Res* 1974, entitled, “Ankle sprains in young athletes. Relation of severity and disability”. The authors were Douglas Jackson, M.D., CPT Robert Ashley, and MAJ John Swanson. Dr. Jackson, MAJ Swanson and associates published another paper, “Injury prediction in the young athlete: a preliminary report”, *Am J Sports Med* 1978.

After West Point, I attended Emory University for my Masters in Medical Science and this was followed by a 3 year tour as one of three AMSC counselors. My responsibility was recruiting in a 21 state area for the PT,OT and Dietetic student programs. I also was promoted to Major in 1978.

My next assignment was Ft. Hood where Doug Kersey was the Chief. Our patients were direct access from the many troop clinics. My initial responsibility was providing care on the hospital wards (ward therapy) and also included teaching OB exercises to expectant mothers. One of my out-patients was an Army doctor, osteopathic physician recovering from knee surgery. We had many occasions of one on one where he taught me many manual therapy maneuvers which I carried forward in my practice. I also attended several manual therapy courses by Stanley Paris which further enhanced my clinic treatment.

From 1982 to 1986 I served at the 97th General Hospital in Frankfurt, West Germany. I do not recall any required special training to provide direct access physical therapy care, but all of us were self-motivated to continue to learn and provide the best care.

I remember one work day, as it was ending, an ambulance arrived with a soldier with an acute back problem. Orthopedics called me after neurologic problems were ruled out and asked that I see this patient. I evaluated him, treated him with ice and mobilization and he walked out with good relief.

Another patient was an anesthesiologist who called and said, “Bob, you need to help me”. His head was held to the side and unable to move, I used ice and mobilization and he was better. I did not know he was an osteopathic physician but told him to check with me the next morning He did not show but later that day, I checked and he was fine.

The diversity of needs and care was broad. I helped to set-up an “Exceptional Child Clinic” in a German building. Also, weight restrictions were now enforced and I did not like them. I taught classes for personnel in dispensaries to measure skin folds as I was the “monitor”. I was upset that some good people were discharged from the military because of the Army standards. I was also promoted to LTC at this tour.

After Germany, I relocated to FT Leonard Wood where we had direct access and saw a great number of patients as this was a basic training post. Manual mobilization was a big part of our treatments. We also had a very active education program with students from the Army P.T. programs, students from the University of Missouri P.T. and another school for P.T. assistants from St. Louis.

I retired in 1990 and returned to San Antonio. My military career “could not have been better.”

COL James Reid

I am not an army trained physical therapist but graduated in one of last classes of DT Watson School of Physiatrics which relocated to the University of Pittsburgh in 1969. *Editor’s note: the DT Watson Home for Crippled Children was opened in 1917 and ten years later the School of Physiatrics was started, one of the first physical therapy programs in the US (Historic Timeline Western Pennsylvania Disability History and Action Consortium).*

I do not recall a date or place where direct access started but I was taking numerous Army and civilian NMSE related classes/in-services. I do remember taking an extensive Army-sponsored NMSE course in the early '80s which included physicians, nurses, pharmacists and PT instructors.

One incident that stands out happened while I was at Madigan (late 80's I believe). The female Chief Physiatrist from DC was visiting and wanted to know some information about our sick-call clinic. She had let me know she was not in favor. She came along with me one morning. I saw a few obvious PT patients and set them up for Rx. Then a young, black female soldier was referred for back pain. With just a few questions it was obvious this was not a musculoskeletal case so I referred her to the surgical sick call clinic as a possible menstrual cycle issue (which we did find out later she had developed an acute infection). The Chief Physiatrist never was on my case about PTs doing sick call again after that visit.

I also recall that at FT Campbell, we had direct access as patients were referred to us for evaluation from TMCs or the ER where they had been seen only by a 91B or 91C (enlisted medical trained personnel). I retired in 1995.

COL William “Bill” O’Grady

After graduating from high school, I was drafted into the Army at age 19. Following my discharge, I used the G-I bill and earned my physical therapy degree at Long Beach State in 1972. I went on and received a Master’s degree at University of Southern California and my doctorate at the University of St. Augustine in orthopedic PT later. I returned to active duty as a physical therapist in the late 1970s.

At first, it was rather overwhelming and frankly intimidating to start practicing as a primary care PT in the Army. Prior to this I remember us civilian PTs were treated more like technicians. I even needed a physician’s permission to change the wattage intensity on the ultrasound machine. Fortunately, while at Fort Bragg I was lucky enough to have a supportive and wonderful mentor in COL Jane Gierhart who spurred me on to be very proficient in orthopedic physical therapy.

In those days the Army had the neuromusculoskeletal care course which was taught by Duane Saunders. At the same time, I became certified in manual therapy by Stanley Paris. The exposure to both of these gentlemen gave me the additional confidence to practice primary care in the Army. As a result, I was one of the first people to be awarded the additional specialty skill identifier 8G as a NMS specialist. Dave Greathouse and a few others were awarded this around the same time.

Another bonus as I remember was that Florence Kendall served as a consultant (to the Surgeon General of the US Army) during this growth of direct access in the army. She was a great mentor for the Army as her teachings elevated the standards of care of us Army PTs.

While at Ft. Lewis, I had an ROTC cadet that fell on her buttocks injuring her coccyx. She was in significant pain. The radiographs revealed that her coccyx was flexed in toward her large intestine. I did a coccyx manipulation and she became asymptomatic. COL Sandy Hall upon seeing this decided I was the “go to” therapist for coccyx and other pelvic issues.

Another distinct patient I recall had an unusual nevus on her back and I referred her. It turned out to be a malignant melanoma. It saved her life. Additionally, another female patient presented with pain at T12-L1 which was unusual site for pain until she revealed that she had a recent history of breast cancer. I referred her to oncology and the doctor dismissed it because she just had a bone scan 3 months earlier which was negative. Her husband pushed for more evaluation; and indeed, she had metastases. While I was not trying to play doctor, I had enough sense to know my limitations.

The Army taught me to be a confident clinician yet also taught me to be wary of red and yellow flags and do not be hesitant to order imaging or lab tests but also send them on to a specialist. It was not uncommon for us to detect underlying diseases and red flags as a result of our assessment.

I was assigned to Saudi Arabia during the first Gulf War – 1990-1991. In the clinic, there were two male PTs and one female PT. The Saudi PTs did not like to touch patients and preferred to use various machines to treat them. Hence, the more “hands on” manual treatments were left to myself and the other two PTs. One day one of the Saudi princes came into the clinic with a complaint of lower back pain. He went to New York previously for a bunch of tests and treatment and was still in discomfort. We evaluated and treated him with manipulation which easily fixed the problem. He was given home exercise and asked to return in two weeks. My fellow PT, Steve Black had taught him the home program. A few weeks later, the prince returned for a recheck. We asked him to show us his exercise program and the young Prince snapped his fingers and his body guards immediately got on the floor and performed the exercises giving us all a great laugh.

When evaluating another patient with low back pain I detected some ataxia and referred him. He was found to have a space occupying lesion on his spine. Another patient had been involved in a MVA. He was dizzy and had odd symptoms to go with it. He was stable but something was off. Ultimately, I referred him out after manually assessing him. He ended up having congenitally missing odontoid. He ended up in surgery. I was very glad I did not try to manipulate or mobilize him.

COL Ron Franklin

I graduated from Case Western Reserve University in 1969 with a Master’s Degree in Physical Therapy. The director of the program was Geneva Johnson PT, PHD, FAPTA and her assistant was Dorothy Pinkston PT, PhD, FAPTA (veterans of the Army and Air Force respectively). They were both advocates of elevating the physical therapy profession to *direct access*. I was about to be drafted so I joined the Army with a direct commission to be a physical therapist with my first assignment to Valley Forge General Hospital.

Next I was transferred to Bad Kreuznach in Germany and met my wife Linda, a graduate of the University of Kansas Physical Therapy Program; she also had a direct commission into the AMSC. After serving at Walter Reed, she was transferred to the 2nd General Hospital at Landstuhl, eventually she worked in a civilian German Hospital in Ludwigsburg . Later I was transferred to the 5th General Hospital, Bad Cannstatt (Stuttgart) and served there from 1971 to 1974. Although it was not regulation, I felt that I had some direct access because the orthopedic doctors wanted me to screen patients before they were referred to them.

Upon returning to CONUS, I became an Assistant Professor at the Army-Baylor Physical Therapy Master’s Program 1974-1979 and taught with COL Mary Lucas and COL Beth Hamilton. The entire program was designed for evaluation and treatment, although direct access wasn’t really discussed much. It was assumed that our graduates would experience “eval/treat/refer if necessary” in their Army hospital assignments. In 1979 I PCS’d to Madigan Army Medical Center and later to Reynolds Army Hospital at FT Sill and direct access was practiced at both facilities. I returned to Brooke Army Medical Center (1993-1997) and worked with COL Gail Deyle PT, DSc, FAPTA. We helped to develop the 1st Army clinical doctorate in

physical therapy with emphasis on direct evaluation and treatment. This program was designed for physical therapists because the doctorate of physical therapy degree was becoming the entry level degree for the profession.

COL David Greathouse

In 1968, I graduated from Marshall University with a degree in Physical Education and Biology. During my years at Marshall University, I was a varsity wrestler for the Thundering Herd. In 1969, I earned my physical therapy certificate from the D. T. Watson School of Physiatrics in Leetsdale, PA. I was a member of the last class to graduate from DTW, as the PT program moved to the University of Pittsburgh in 1970. One of my DTW classmates, LT Ellie Menold also entered the Army as a PT and was assigned to Madigan AMC. Unfortunately, her budding career stopped when she was tragically killed in an auto accident in 1971.

The summer before graduating from Watson, recruiters from the Air Force, Navy and Army visited us. Being married with one baby son, I liked what the Army had to say and I applied and joined the Army for two years. I received a direct commission and started basic officer training in January 1970 where Dick Schreck was also a member of my OBC (Officer Basic Course). We started a close professional and personal friendship throughout our military careers and continues today. I was assigned to Walter Reed General Hospital and had rotations in the out-patient clinic before moving to the orthopaedic wards. In 1971, I was sent to the prosthetic course at Northwestern University and then became the amputee coordinator at Walter Reed AMC. Gil Sosa was my predecessor as amputee coordinator at WRAMC PT and had set up an outstanding program for our Vietnam vets.

In January 1972, I PCS'd to Ft Riley and worked with CPT Al Woerman and LTC Sandy Hall (Chief PT). In 1973, LTC Sally Lopez became Chief PT at Ft. Riley and our clinic was chosen as one of four demonstration sites for Army PT's new neuromusculoskeletal evaluation (NMSE) program. LTC Lopez put me in charge of implementing the NMSE program and the eventual move to direct access. We initiated education and training programs in orthopedics, radiology, pharmacology, lab studies and general medicine to prepare us for our roles as physician extenders, and had the full support of the hospital command's, orthopaedics, radiology, and pharmacy departments. We also started a PT on call system for night and weekend care which was a great idea but difficult to manage with only 3 PTs.

In 1973, the Army contracted with Dr. Stanley Paris to teach his S-1 (Manual Therapy) course for Army PTs to assist with training and education in the evaluation and treatment of patients with NMS problems. This course, held at Fort Sam Houston, TX was attended by 20 to 25 people including Rick Ritter, Doug Kersey and Duane Saunders. The course was 10 days long and was filled with lots of manual therapy evaluation and interventions. At this time, Duane Saunders was an Army reserve PT who had a hospital and private practice in Great Bend, KS. Subsequent to the Paris course, quarterly manual therapy/NMSE meetings were held between the Fort Riley and Great Bend PT staffs to enhance their training in NMS and manual therapy.

In the late 1970s and early 1980s, there was a decision to develop Army regulations to support direct access and this occurred at the Office of The Surgeon General (OTSG). When we started NMSE at FT Riley we established a physician's oversight program which was usually an orthopedist and a continuous quality improvement (CQI) program for self and peer assessment. Other medical services, including pharmacology, radiology and internal medicine provided oversight in the various medical facilities.

In 1975-1976 I studied at the University of Kentucky, Lexington and earned my Master's degree in Education, Physical Therapy and had formal training in electrodiagnosis (EMG and NCS) in the Department of Neurology. I was assigned to the PT Clinic at BAMC from 1976-1978 where I worked primarily on the wards developing programs with neurosurgery, neurology, and internal medicine for PT evaluation and interventions. During this time, Dick Schreck and I also assisted at the Army-Baylor MPT program (AMEDD Center and School) teaching manual therapy evaluation and treatment techniques to the PT students.

In 1978 - 1982, I was assigned to the 196th Station Hospital, Supreme Headquarters Allied Powers Europe (SHAPE). I initiated the NMSE program at this clinic and I had the opportunity to work with two Belgian orthopedists and a British physical therapist who had trained with Dr. James Cyriax who is called the "father of orthopedic medicine". During my time at SHAPE, the Army initiated its first formal course for educating and training military physical therapists for their roles as NMSE providers. COL Lucas was the Project Officer and she appointed me as Course Director (before I deployed to SHAPE). She also arranged for me to return to the States to help with the teaching of the first 2 NMSE Courses. Other PT faculty assisting with the first NMSE course were MAJ Doug Kersey, MAJ Rick Ritter, and MAJ Dick Schreck. This course later became the Kersey Neuromusculoskeletal Evaluation course, named for COL Doug Kersey. In the early 2000's and post 911, the Kersey Course curriculum was changed to focus on training PTs to prepare physical therapists to provide their expertise and services in more forward military operations.

After receiving my PhD degree in anatomy/cell biology in 1985 from the University of Kentucky, I became the Program Director, U.S. Army-Baylor University Graduate Program in Physical Therapy AMEDD Center and School, Fort Sam Houston, TX. During this time, COL Duane Saunders was my Individual Mobilization Augmentee (IMA) and assisted with providing the yearly NMSE (Kersey) Course which was held at the AMEDD Center and School. In 1990, I was selected as the Chief Physical Therapist Section and Assistant Chief, Army Medical Specialist Corps, OTSG. I became the Chief, Army Medical Specialist Corps, OTSG in 1993 and during my time at OTSG, the regulations for the NMSE and direct access program were reviewed and revised to meet the current practices of Army PTs performing NMSE. I retired from active duty in 1996 – "coming into the Army for 2 years (for experience) and staying 26 years".

LTC Richard Ritter

After 2 years of pre-med study at Montana State University (MSU) I was accepted to PT school at Marquette University and earned my BS degree in PT in 1967.

I applied to the Navy for a commission but was turned down because I am a male. Knowing that I had 2 years of Army ROTC at MSU, I contacted them and they helped get me a direct commission. Before starting Officer's Basic at MFSS, I worked as a PT for several months. I got my orders to FPO, San Francisco (FPO stands for Field Post Office). This meant my 1st full duty assignment was to be Japan. Being a little concerned, I contacted a retired SGT MAJ and he said, "you'll love it".

He was correct. I met my future wife, Linda, an Army nurse and my working colleagues were great. Our case load had a lot of good patients and some terrible ones. In 1969, I PCS'd to Madigan and then to FT Wainwright in Fairbanks, AK. There was not a great deal of independent direct access at my 1st two assignments but it became more "official" when I was in Alaska. The orthopedic doctors and I worked out a process that I would see patients without referral. It was my decision.

As time approached for my next move, I learned that I would be going to Martin Army Hospital in FT Benning, GA. Not overly excited about this, I learned that CPT Mike Smutok, working at FT Sill, wanted an assignment at FT Wainwright. We contacted the assignment personnel and they thought that was a great idea. We traded places.

At FT Sill, we did a lot of screening and we initiated functional activities in our rehab programs. The orthopedic doctors and I worked out a process that I would see patients without referral. It was my decision whether or not to send the patient to orthopedics.

Also at Sill, there was a little bit of a rub with the Army recruiters whose purpose was to get people into the Army. We were screening after they got in and our purpose was to find, treat and prevent injuries. In the end we had a good result with all people in agreement.

I next went to Letterman Army Medical Center where we treated a large number of patients with lower extremity joint replacements. It was a great pleasure to work with CPT Stan Conte who left the Army and started a private practice in San Francisco area. Eventually, he went to work with the SF Giants baseball team.

My last duty station was the US Military Academy, West Point, NY and served there for 6 years, 1981-'87. Our patients were mostly cadets and staff and there was direct access. We also provided care to the athletes; I worked with the baseball team. We were able to apply what we knew and had good respect from the orthopedists and athletic training staff.

During my military career there were a fair number of times that I found ligament sprains or muscle tears, not found or reported by others. One 'thinking-on- your- feet' situation occurred while serving with a Reforger Operation that included French and German forces. This was direct access and a soldier came in with what could be a finger fracture. But, I had no equipment and there were no x-rays. If it were a fracture, I wanted to confirm it. I contacted the dental group and explained the situation and they agreed to make the radiograph which confirmed the fracture.

I retired from the military after West Point and joined Stan Conte in San Francisco. Also, I want to note that, an early male AMSC PT was very helpful.

MAJ Ron Scott

After high school, I entered the Navy in November of 1969. Completing Basics, I went to Surgical Tech School and then on to Bethesda for 6 months to become an OR (operating room) Tech.

I spent some time in Charleston, South Carolina then on to Rota Spain where I met my wife Pepi. In Spain, I did everything including working in X-rays, the lab and sick bay. I also took care of wounds. I would run with the Marines and had an unusual experience during these runs. A Marine Captain and a Navy LT physician required me to run carrying an M60 Crew-Served weapon. IT was heavy and I struggled.

I learned independent duty.

Before leaving Spain, a few of the sailors traveled to Morocco where they bought some marijuana. The guy who sold the illegal substance told the Spanish authorities and they were waiting for our sailors in Spain. The guys jumped into a car and raced to the ship. The Spanish authorities charged up the gangplank but our Captain denied the Spanish entrance saying they did not have approval to board the ship. Although the sailors avoided the Spanish, the Captain took care of them and placed them in the Brig. I did guard duty.

On the trip home from Rota, some sailors pulled a stupid prank causing our ship to lose power for 13 minutes in the Bermuda Triangle.

Upon return to the States, I had a candid camera experience. The Navy Bureau of Personnel gave me orders to Vietnam for my last 10 months of service. I explained that I was married and had only 10 months to serve. So they gave me an offer to work as an OR Tech in Jacksonville. I had to look around for the 'Candid Camera' moment.

I felt very independent with my duties in Jacksonville and this wetted my appetite for physical therapy. I attended the University of Pittsburgh 1975-77, where I am proud to say that I was named a Mary McMillan Scholar. I recall telling our director, Rosemary Scully, that "I foresee physical therapy becoming independent".

My first job was at Mercy Hospital where I was required to rotate among various physical therapy services. I thought this was excellent because it broadened my knowledge and experience as I provided care in 4 different settings; including out-patient, cardiovascular, pulmonary and burn care.

COL Mildred Wood called and asked if I might be interested in returning to the Army as a physical therapist. I happily accepted the position and started at FT Leonard Wood, MO. I had the good fortune of serving under COL Jim Roberts, LTC Yamamoto and CPT Cathy Neveux. They gave me free reign.

I recall a special patient that I treated for 9 months. This young female had a closed head injury. Her family was at FT Carson, CO and there was a request to transfer her to Fitzsimmons but I did not think she was ready to go. I requested OT to be involved and I remember using a hand electrical stimulator to get her muscles working. I was proud that she progressed from being comatose to walking with 2 canes. She returned to Colorado to complete her rehabilitation.

I applied to the law program which upset the AMSC leaders because I occupied a PT slot. This was remedied by transferring me to the Medical Service Corps and assigning my position to the Pentagon.

I attended the University of San Diego, 1980-83 for law school. After finishing, I transferred to the JAG and was assigned to FT Meade, MD. Additionally, during this tour, I worked at the Greater Laurel Hospital on weekends providing physical therapy care.

With the help of COL Becky Storey (Hooper), I got a branch transfer back to the AMSC and was assigned as the Chief of PT at FT Polk, LA. I felt my practice there was very independent. We saw approximately 25 patients a day. I did the evaluations and made the physical therapy diagnosis; the PT tech 91J, did the care. I realized that I felt more comfortable in the AMSC than in the JAG. PTs are more helpful.

COL Greathouse called and asked if I would take a position at Ft Sam Houston which I happily accepted. My family moved to San Antonio but my replacement, coming from Korea, had not arrived. As I remained at FT Polk, Desert Storm started and some PT Reservists with rank higher than mine were assigned to FT Polk. Having this manpower allowed me to do some risk management at the base. When my replacement arrived, I was told, 'You are a hard act to follow'.

At Brooke Army Medical Center, I was pleased to work with COL Jones and COL Franklin.

CPT Bill Bracewell

I graduated with a BS degree in physical therapy in 1970 from the University of Florida and received a direct commission to join the Army Medical Specialist Corp. I was assigned in December to Valley Forge Army Hospital the same year where I enjoyed working with Ron Franklin. My fellow female PTs at Valley Forge, who had been taught by COL Marilyn Anderson at BAMC, contacted her (as she had become the PT Corps Chief) and arranged for me to be assigned to FT Sill as the chief at Valley Forge was not enamored of my lack of military "behavior" and my six month active tour was due to end). Ft. Sill turned out to be an outstanding opportunity to work with MAJ Bob Doctor. He was keenly interested in orthopedic physical therapy care and was an outstanding mentor.

In 1971, MAJ Doctor and I attended a party with some of the orthopedic doctors from FT Sill. They were complaining about their extra work of having to go to troop clinics at 0500 to screen soldiers with low back pain. I told Bob Doctor that I would go to the troop clinic to do the screening so that the orthopedic doctors did not have to do that. This was the start of direct access for me and PTs at Ft. Sill. Later, 1LT Mike Pagliarulo also became involved. I should add that the Public Health PTs were also evaluating and treating when I did my internship at the USPHS facility, New Orleans in 1970.

I saw approximately 30 back pain patients each morning. In the beginning, for the most part, if I found an absence of neurological signs, I sent the soldier back to duty. Having had a Stan Paris course and realizing that I needed to do more, I expanded my physical examination to include range of motion, palpation and testing for segmental movement. I think we could order x-rays, change profiles, place persons on quarters and prescribe APCs (Aspirin, Phenacetin, Caffeine).

After having been taught Chronaximetry and Strength Duration Curves to help diagnose nerve disease and injury, and having interned at a Public Health Hospital in New Orleans where PTs were already doing EMGs, I was able to use those skills at Valley Forge on Vietnam era patients with nerve injuries. Later, at Ft. Sill, CPT Dicky Huey, a neurologist who was assigned to Ft. Sill and I acquired an EMG machine and helped each other learn to do EMG testing.

1LT Mike Pagliarulo and I were doing lots of manual and mat therapy and realized our starched white uniforms were not very appropriate and looked terrible after even a couple of hours. MAJ Doctor approved a change to khaki bottoms and white tops, which later became the standard for the corps.

Ken Morris and Barbie Reed PCS'd (permanent change of station) to FT Sill. I transferred to Lanstuhl, W. Germany, 2nd General Army Hospital in 1973 where I continued to do about 30-40 EMGs a month.

CPT Michael Pagliarulo

I attended the University of Buffalo and earned a degree in Biology. I was a double major so needed a 5th year to complete my Physical Therapy education. However, college draft deferments were good for only 4 years; thus, I was reclassified 1A (available for military service) after I received my degree in Biology. I went to my local draft board with short hair and well-dressed to plead my case to continue the deferment a 5th year to complete my physical therapy school requirements. Denied, so I remained 1A with a low lottery number. I was fortunate to have a clinical affiliation at Walter Reed Army Hospital in the spring of 1970. During that time, I met some high ranking officers and learned some Army behaviors/procedures, as well as the direct commission program for PTs in the Air Force and Army. I applied to both to avoid the draft and was accepted into the Army program. I delayed accepting that offer...until I graduated with my PT degree and received my draft notice, 6 weeks later. I returned to the draft board with both my draft notice and the acceptance letter. The woman with whom I spoke was uncertain that this could happen, so she called her boss in Boston. After a few “uh-huhs”, she put down the phone and told me I could enroll in the direct commission program. What a relief!

Later that summer, I attended Officer Basic Training at Ft Sam Houston, then was assigned to Fitzsimmons Army Hospital in Denver, Colorado. There I learned that patient care was more important than shiny shoes and short hair. The physical therapy services were excellent, and I learned top level care for individuals with amputations and lower limb prosthetics.

At Fitzsimmons, we treated many war casualties but also persons needing long term care for chronic conditions. Some of these patients were in the hospital for months and some for up to one year. An excellent social worker realized that as these persons, who were treated in the protected hospital environment, became more anxious as their discharge date approached.

This social worker had good connections with ranch owners in Montana, and developed a superlative plan to help these long-term patients transition to the civilian community. An arrangement was made for about 2 dozen of these military members for a 1-week stay at large ranches in the area of Bozeman, Montana. A physician, a nurse and a physical therapist were required to accompany these military members to the ranches. I volunteered and was very happy to participate in this process. At the ranches, the patients greatly enjoyed the opportunities to fly fish, horseback ride, bugle for elk, and skeet shoot. Some of the guys with amputations were strapped into saddles. The benefits of this transition helped these persons with permanent injuries to realize that life outside the military can still be worth living.

While I was ambulating a patient in the hallway, the chief of PT approached from behind and asked if I would be willing to be transferred to Ft Sill, Oklahoma. Without knowing if I had a choice, I agreed and left Fitzsimmons after approximately 11 months.

I learned quickly of the big differences between Fitz and Sill. Acute care was the focus at Ft Sill where I had the great opportunity to learn from Major Bob Doctor and Captain Bill Bracewell. Major Doctor had an advanced degree in hospital administration which allowed him the ability to work also with the hospital commander and other medical service corps chiefs.

I felt that I was among the first PTs to do Direct Access. We saw individuals with back, neck, and knee problems. I was allowed to order x-rays and arrange for orthopedic

emergency consults. The doctors loved it and believed that the PTs were doing great triage and that meant that when they got a referral from a PT there was something wrong and that the patient really needed their orthopedic evaluation and care.

Because I could order x-rays, I quickly learned a great deal about radiology. After ordering x-rays for a few patients with scoliosis, the radiologist told me that there was too much exposure to radiation when doing a full scoliosis series. That taught me that I needed to think twice about what I ordered.

It was interesting that the white uniforms worn by the enlisted persons were identical to our officer uniforms except for the shoes. We wore white shoes. They wore black shoes.

Major Doctor asked the hospital administration if the PTs could wear the same uniform as the physicians. His request was approved. It was enjoyable to notice that when my uniform changed, I was addressed differently. I was now called Dr. 'P' by my patients and in my all-white uniform I had been addressed as LT "P".

Having been a young therapist and gaining skills, I always used my goniometer to measure joint motion. One of our techs, Mr. Brown, taught me to see the range of motion with my eyes and not with the goniometer. He looked at a knee and said there is 45 degrees of flexion. I measure it with the goniometer at 45 degrees.

Because the Viet Nam War was slowing down and there were fewer casualties, I was offered a 3-month 'early out' which I accepted and I was promoted to CPT. After discharge I took full advantage of veteran benefits, including assistance in pursuit of a 2-year Master's degree program in PT. I currently enjoy medical benefits from an excellent VA hospital in Portland, OR. I continue to look upon my Army experience with great pride and gratitude.

CPT Pat McAdoo

I graduated as a member of the University of San Francisco's second coed class in 1969 with a BA in psychology/pre-physical therapy. If I didn't get into Physical Therapy School, my back up plan was to obtain an elementary school teaching credential. Fortunately, I was accepted by the US Army PT program at the Medical Field Service School, Fort Sam Houston, Texas, and my career started with attendance at the Officer Basic Course in July, 1969, followed by The Physical Therapy Course (6H-3418) which ran from 15 August 1969 through 27 August 1970. It was an exhausting and intense program---literally, we were on duty 24/7. We spend a minimum of 40 hours per week in the classroom/practice labs/clinical facilities at Brooke Army Medical Center.

When discussing the process of getting patients into physical therapy, COL Marilyn Anderson emphasized that "evaluate and treat" was the best referral---for both the clinician and the patient. It minimized paperwork as one referral covered the entire episode of care and the patient was able to progress smoothly. In ALL CASES, regardless of the wording (or lack of same) from the referring provider, the accepting physical therapist was responsible for a complete evaluation of

the patient PRIOR to initiating any treatment. If there were significant differences between the referring clinician's findings and those of the physical therapist, an exchange of thoughts and findings should occur. No way could you get away with "but Dr. Soandso said to..." As a clinician, you were responsible for the care you delivered.

Upon graduation in 1970, I was assigned to Letterman General Hospital. The practice at that time was for the new graduates to be assigned to one of the large general hospitals such as Brooke Army Medical Center (San Antonio TX), Walter Reed Army Medical Center (Washington, DC), William Beaumont General Hospital (El Paso, TX), Fitzsimmons General Hospital (Denver, CO), Madigan General Hospital (Tacoma, WA), Valley Forge General Hospital (PA) or Letterman General Hospital (San Francisco, CA). At that time, these were the Army's teaching hospitals and they each had many residency programs.

At Letterman, there were both a Physical Medicine and Rehabilitation Residency and an Orthopedic Residency. As a result, all outpatient referrals came through these programs. Direct Access was not a formal protocol at the time but we evaluated each of our patients and we had the ability to resume PT care for a former patient by having a quick chat with the referring physician.

I left Letterman in the summer of 1971 to head to Fort Campbell, KY.

As the draft (including the physicians' Berry Plan deferments) wound down in the early 1970s, the shortage of physicians became more acute and the military began to explore various remedies. The first class of physician assistants began their clinical education in 1972-3. Many of these gentlemen had been combat medics during the Viet Nam conflict and/or Korean conflict and did not have a bachelor's degree. Initially, they were warrant officers. For the most part, they worked well with the therapists. (All were men as women were not allowed in combat roles at this time).

While formal protocols were perhaps a bit late in coming, many informal arrangements were forced in the station hospitals among Outpatient clinic staff, Orthopedic staff, Physical Therapy staff and the PAs in the Troop Medical Clinics. A phone call could usually get the patient seen within 24 hours in Physical Therapy. Depending upon the finding, the patient was treated in physical therapy, returned to the original provider or sent on to a specialty clinic, usually Orthopedics or Surgery.

Occasionally, an overworked troop medical clinic staff would "push" a patient on to PT having done the paperwork but not the clinical exam! I recall evaluating a low back pain patient from one of the TMCs and quickly observed that he had a pilonidal cyst! Fortunately, the surgical clinic was close and receptive to my referrals. Originally, PTs could not write profiles but this too gradually made its way into reality. Originally transcribed as "per verbal order of Dr. Soandso" it finally evolved into the PT's signature.

Many of the station hospitals lacked occupational therapy and we made splits using the hydrocollator to heat the thermoplastic material. In many, if not most, of the station hospitals, Physical Therapy and Orthopedics were located somewhat near to each other. The on-going

interaction (both social and clinical) helped to form a tight team and enhanced the flow of patient care by building clinical skills and by facilitating and smoothing the formal referral practice. In my single-therapist clinic in Seoul, Korea, I quickly appreciated the fact that both the Internal Medicine and the Outpatient Clinic providers realized it was much easier, more pleasant and more effective to walk a patient down to the PT Clinic than it was to fight through the bureaucracy of an Orthopedic referral. And, importantly, Orthopedics was willing to see referrals from Physical Therapy on an expedited basis since they knew that the patient had been screened and supporting lab and imaging had been obtained. This was due in no small part to the willingness of the Lab and X-ray to accept orders written “per the verbal order of Dr. Soandso”.

These practices evolved informally (due both to the physician shortage, the lack of financial remuneration based upon the number of patients seen, and to the unique legal status of active duty clinicians) but eventually their success mandated that they be formalized and quantified.

There were some moments of humor in all the chaos---one time I realized that the young soldier I was examining had hemihypertrophy and spent some time working to get an appointment with a geneticist for the young man and his wife. Getting that paperwork signed and funded was no easy task!

I left the Army in 1979 as a captain with ten years of service to join the US Public Health Service.

During the draft years, the USPHS had been an alternative to military service and so it, too, was experiencing a shortage of providers. This offered an opportunity to work with the physician and physician-extender staff member

LTC Tim Kauffman

As a Gettysburg College student I joined ROTC in 1968 because I thought the Vietnam war was not going to pass me by. After returning to college from FT Benning, GA, I told my officers that I wanted to become a physical therapist. They were pleased to tell me that the Army has a PT School. I wrote to the school, (MFSS), and got a curt hand-written note, saying this is “for females only”.

Undeterred, my officers told me to apply to physical therapy school. I got into the University of Pennsylvania and E. Jane Carlin, who treated President Franklin Roosevelt when she served at Walter Reed Army Hospital, wrote to the Army saying that U of Penn had accepted me and that I can be deferred. Jane Carlin was a Brigadier General, something I did not know as a student. Later, I learned that she was in the Air National Guard although I have read reports saying she was an Army BG. My search of Jane’s military history could not confirm that she made the rank of general.

After completing my didactic PT education, I was delighted to receive a letter from the Army saying I was promoted to 1LT and had a branch transfer to the AMSC. Less than a week after graduation, I was back active duty, first to MFSS.

In January 1972, I reported to Madigan General Hospital. The following year, LTC Bea Thompson (awarded a Bronze Star for her tour in Vietnam), Chief of Physical Therapy at Madigan told us that because of the changes to the draft and the end of the Viet Nam War, there are shortages of doctors and that we would be granted new privileges as PTs. She informed us that COL Marilyn Anderson, Chief of the Physical Therapy Section at the Surgeon General's Office had this new activity approved.

The procedure was that after a serviceman reported to "sick call", for low back pain and had no neurological symptoms or trauma, the corpsman would refer the person to PT for "evaluation and treatment without physician referral". At that time in 1973, we were not approved to evaluate and treat any other body complaint.

I, like all of my colleagues felt this is a great initiative and that we were up to the challenge. I do not recall having had any specific additional training but we had in-services frequently. I do remember a voluntary training, multiple evenings after a clinic member, and maybe there was a 2nd member, who attended a Stan Paris extremity manual therapy course. We all studied evaluation procedures and techniques. Before this process of "without physician's referral", we always did our physical therapy evaluation even with the referral from the physician.

In addition to treating the person, we could order x-rays, issue a limited profile (restricting the service member's duty), place the person on quarters (stay at home and no need to report for duty) and prescribe limited medication (APC, acetaminophen, phenacetin and caffeine).

It was interesting and I recall a sense of pride that a radiologist told me that he was pleased to have PTs ordering x-rays because he knew that we did thorough physical examinations and that he was likely to see radiographic changes.

I recall being required to present our cases to one of the physiatrists at the end of each day. This was a safety net to insure that we did nothing wrong. Although we were questioned about our decisions and actions, nothing in my memory indicates that we did anything wrong from the physician's view and nothing was altered in our plans of care.

In 1974 I arrived at the US Army 5th General Hospital, Bad Cannstatt (Stuttgart, West Germany) which provided care to US troops in Baden- Wurttemberg including Patch Barracks, the European Command of US troops. During my in-processing meeting with the Deputy Hospital Commander, I explained that PTs now can evaluate and treat patients as was done at Madigan. The colonel was receptive and the procedure was approved by the Chief of Orthopedics, under whom PT was located in the chain of command. The orthopedists were ecstatic because none of them enjoyed the many LBP evaluations.

After completing one day in the PT Clinic, I was the administrative officer of the day (AOD) which kept me up most of the night. At 0800 hours after AOD, I returned to my PT Clinic for my daily duties. Late in the afternoon that day, I had a “direct access” back pain evaluation of a young female military member. I was very tired but little of the history or physical examination lead me to think of a musculoskeletal back problem. Her vague responses to my questions about her menstrual history lead me to a referral to the medical lab for a pregnancy test. It was positive. Thank God, I was alert enough and I trusted my evaluation skills to request the test.

A second event which was most enjoyable and memorable was a call from the Chief of Orthopedics who requested me to be present at his evaluation of the 4 star general, Commander of the US and European Forces. When the hospital was contacted about the need for an evaluation of the commander’s LBP, of course my rank of captain was not high enough to be the primary evaluator. But, the Chief of Orthopedics trusted my PT perspective enough that he made the General wait until CPT Kauffman arrived. The LTC Orthopedist did his examination and then he asked, Tim, what do you think and what else do you want to do? The General was completely confident with my evaluation and care plan and this inclusion helped build the value and foundation of “direct access” to physical therapy.

After leaving active duty in 1977, I joined the 99th Combat Support Hospital, Lancaster, PA and later the 56th Station Hospital Reserve Unit, Richmond, Virginia. It was interesting that years later, 1983, I had to take the Army-sponsored Musculoskeletal Assessment for Physical Therapy Officers Course before I could use the direct access process, whenever I was active duty as a reservist. The course was taught by Reservist COL H. Duane Saunders.



Madigan Army Medical Center, circa 1973. Physical therapists L-R: LT Kauffman, LTC Putnam, LT Zarbano, CPT Going, MAJ Sakson, LTC Thompson, CPT Sorenson

LTC Marilyn Miller

I graduated from Wisconsin State University at Stevens Point where I majored in physical education with an interest in dance. The same year, 1970, I got acquainted with PT through an Army program which placed college students for 30 days at the 8 major Army medical hospitals. I liked it and began my studies at the Army Physical Therapy Program, MFSS, FT Sam Houston. As Army physical therapy students we went on rounds with orthopedic and neurologic residents. Often, we were asked to answer questions that the residents couldn't answer, so this was a great learning experience for us and the doctors. As an Army PT student, I had an affiliation at a civilian institution, University of Texas Medical Branch in Galveston, TX. It was interesting because we had a few evaluation and treat referrals/orders in that location, as well as in Army sites.

We were the last class (1971) before the Army-Baylor program started. Three months before we were to graduate, the MFSS PT program Commandant asked us if we were interested in extending 3 months to earn our Master's Degree. In my class of 20 students, 18 indicated we were; but subsequently, were told that was unexpected and NOT available to us! So the offer was given and then rescinded.

My first duty assignment after graduation was at William Beaumont General Hospital, El Paso, Texas. We had a good relationship with orthopedics and they appreciated what we recommended. It was wonderful to become a pilot project for the gold pants suit which was to replace the white dresses worn by the nurses.

At that time, joint replacements were new, almost experimental so we collected data. We typically used equipment like Stryker Frames for SCI and Circ-0-lectric beds for joint replacements.

I separated from active duty in 1972 and joined the Reserves. I did some Reserve duty at FT Rucker, Alabama where I treated injuries among helicopter crew and airborne troops. At FT Benning I saw injuries sustained by infantry members and their dependents. Tripler was different with its mixed tri-service practice and dependents as well as multicultural persons from the Pacific Basin and Vietnam/Cambodia.

COL Nancy Prickett

After earning my undergraduate degree with a major in Health and Physical Education from West Chester State College I graduated from the Army-Baylor PT program in Nov. 1973 with a

MPT. I believe treatment without referral was discussed in class and in the clinic, but without definite procedures. Many clinical PTs felt they could treat musculoskeletal conditions without physician referral. My recollection is that it was a feeling. As a student and a new PT I was aware of this thought, but busy trying and focusing to establish myself as a clinician and a professional.

It was scary or better put - a challenge- to be a provider without a physician referral in 1975-76. I had attended Stan Paris's first back musculoskeletal course and this qualified me to be a provider without referral at Fitzsimmons Army Medical Center where I served from 1973-1976. I had Captain Allyn Woerman as a mentor in doing musculoskeletal evaluations at Fitzsimmons. He was available to talk with and discuss decision-making

I do not recall having any special or extra training before starting evaluations but the procedure for the musculoskeletal evaluation I used was approved by the PT clinic. As PTs we rotated through this assignment to evaluate patients without physician referral. The Paris course helped.

We did have the ability to begin PT without referral. We could also request x-rays and I believe we could have input to place the patient on quarters or limited duties, etc. I do not recall any specific safe guards, but we could discuss the patient (signs and symptoms) with physiatrists and orthopedists. We had excellent communications and access to both specialty physicians.

I specifically remembered having one case which I evaluated for back pain who demonstrated positive signs for lumbar disc involvement. I referred the case to orthopedics and eventually the patient was diagnosed with a rupture disc and had back surgery - discectomy. I was happy to note the disc symptoms and properly channel the patient towards a surgeon without delay. I left active duty in 1976 and joined the Reserves.

I took the Army-sponsored Musculoskeletal Assessment for Physical Therapy Officers course late in my reservist career. I 'never' used it on 'active duty' as due to the nature of the assignments I had later in my career - mainly in command. But, my very last reservist active duty (two weeks) assignment was in a field hospital in a simulated war zone. Multiple medical units from around the country participated in this medical exercise. The 'experience' was very short on ER doctors (only one was available to cover 24/7) for the 10 day exercise. I was placed in the ER physician/PA position to evaluate and treat in the ER during the day. The qualified physician covered the ER the 12 hours at night. The ER team (nurses and techs) helped me out, but I did have to draw from my total medical career experience (36 years at the time) to handle the cases (from stomach poisoning from the mess hall to sucking chest wounds) which came into the ER. Physicians were present in the ER as Evaluators of the Exercise and guided the scenarios of the cases we were presented with. The physician evaluator was complimentary of the way I managed the team and the decision making for the cases. To me it was an opportunity to 'walk the walk' and at that time I was walking the walk as a primary evaluator in an ER.

COL Nancy E. Henderson

In 1973, I graduated from Washington State University where I initially majored in physical education but changed to pre-physical therapy when I noted the number of physical education majors greatly exceeded the available job positions. One of my clinical instructors was Chris Larson who had recently been an Army PT. After meeting Annie Rush Byers, an AMSC recruiter who came on campus, I made the Army PT School my first choice among six PT schools I applied to. I was overjoyed to receive the letter of acceptance.

I entered the US Army-Baylor Program at Fort Sam Houston in San Antonio, TX in August of 1973 and graduated on 18 December 1974 with a master's degree in physical therapy. COL Elizabeth Hamilton was the Director of the physical therapy program at the AMEDD Center and School. LTC Betty Landen, LTC El-Beheri, MAJ Annie Webb, MAJ Dora "Dori" Sudduth, MAJ Mary Lucas, CPT Ron Franklin, and Dr. Nelson who taught anatomy were our class instructors.

My first assignment as a PT was to Brooke Army Medical Center in 1974. We experienced direct access in that setting. This expansion of responsibility was greatly influenced by the Berry Plan. The Berry Plan was a Vietnam War-era program that allowed physicians to avoid the draft by deferring obligatory military service until they had completed medical school and residency training. It ended in 1973. When the active duty commitment was fulfilled, physicians poured out of the military, depleting the ranks. Physical therapists stepped up to help fill the vacuum in the realm of evaluation and treatment of musculoskeletal disorders.

Early in my career I completed the Doug Kersey Musculoskeletal Evaluation Course, another course taught by COL Dwayne Saunders, and other advanced training. This training, mentoring from excellent military PTs, and being able to practice at the top of my skill set further enhanced my skills for evaluation and treatment without a physician's referral.

From my initial assignment at Brooke Army Medical Center, I moved to the Army Institute of Surgical Research (Burn Unit) in 1976. This was a rewarding but emotionally challenging place to work, with patients either living or too often dying from their injuries. There, I got a call from COL Carole Buss, PT Chief, with an assignment offer to SHAPE Headquarters in Belgium, but I declined. I had been married 7 years and did not want to leave my husband, now a San Antonio police officer, behind.

I left active duty and seamlessly joined Detachment 1 of the 94th General Hospital, an excellent reserve unit where I served from 1979 to 1983. During that time, I also worked at Southwest General Hospital in San Antonio, Texas where I fortuitously learned Spanish. However, the civilian practice lagged behind the military in direct access. All patients could be seen by physician referral only. Many physicians expected prescriptions for physical therapy to be followed as written, even though incomplete or inappropriate. Others accepted my advice to send "evaluate and treat" requests.

Realizing there was no upward mobility and that the opportunity to work at the top of my abilities was limited, I returned to active duty in December of 1983, grateful to be again in an environment where I could be "all you can be," as the Army slogan went.

In 1986-1987, I was stationed 15 months in South Korea as the only physical therapist in country for several months. Captain Bill Tatu's arrival greatly expanded our abilities to provide care as he covered Camp Casey and I was able to extend care to Camp Humphreys an hour south of the 121 Evac Hospital in Seoul where I was assigned.

Enroute to Fort Hood, TX, I earned my Airborne wings at Fort Benning, GA. At Ft. Hood I enjoyed working with LTC Sue Needham and marveled at her amazing work ethic. Upon her retirement, she was replaced by LTC Bob Anderson, another wonderful clinic chief.

Having acquired Spanish fluency, now a major, I was selected to serve as a rehabilitation advisor in El Salvador from August 1989 to January 1990. During that time there were 13 members of the U.S. Army Humanitarian Mobile Medical Training Team with various medical specialties. The counterinsurgency war in El Salvador began in October 1979 and ended in January 1992.

I was the fourth and last of four US Army physical therapists and two occupational therapists who were assigned to this role in six-month periods to assist in upgrading the rehabilitative skills and capabilities of their Salvadoran counterparts. We also obtained experience in combat injuries and enhanced our own medical readiness. Our main objective was to help the Salvadorans conserve their fighting strength so that ultimately, we could conserve ours.

LTC Gil Sosa was the first physical therapist in El Salvador in 1984. He was succeeded by MAJ Rosendo "Ted" Gutierrez. During his assignment in 1986, an earthquake occurred which necessitated MAJ Gutierrez to triage victims with orthopedic trauma and to provide care for many persons with burns. This served as a good example to the Salvadorans of the evaluative and treatment skills of physical therapists. MAJ Gutierrez was followed by LTC Debra Metzger in August 1988.

Our challenges and experiences in El Salvador are presented in an article published in 1994: Henderson NE, Gutierrez RT, Metzger DJ: U.S. Army rehabilitation advisors in El Salvador. *Military Medicine*, 159, 4:341, 1994.

While I was stationed in El Salvador, security measures were imperative. We observed curfews, avoided restricted areas, always travelled with another team member or Salvadoran military person fully armed, and maintained radio contact. "La ofensiva final" began on 11 November 1989 as rebel forces brought the conflict into San Salvador, the capital city. I was on a 3-day pass in Guatemala and was unable to return to my team for about 10 days until there was a lull in the fighting.

I was picked up from the airport by U.S. Marines travelling in an armored personnel carrier and delivered to our "safe house" in the upscale Colonia Escalón in San Salvador. There I shared a large house that had a surrounding protective concrete wall with five other team members. The mood was tense and somber.

Later in November our team was awakened at 0400 by gunfire from a Salvadoran helicopter about 300 yards away. Tracer rounds were returned, confirming the presence of guerillas in our neighborhood. The advice to "take the high ground" proved ill-advised, as sniper rounds entered

the room. CPT Nelly Alemán- Guzmán, our team surgical nurse, was wounded by shrapnel for which she ultimately received the purple heart.

The siege of San Salvador lasted until early December when rebel forces were repelled.

After El Salvador, I returned to FT Hood and replaced Bob Anderson as clinic chief until 1992, when I began a doctoral program at Texas Women's University which I completed in 1995.

In 1995, I was assigned to BAMC in the Department of Clinical Research where I focused my research on injury prevention and readiness of active and reserve Army physical therapists. In 1998, I was assigned to Madigan Army Medical Center replacing PT classmate LTC Joe Dettori.

COL Dettori wisely positioned his therapists to work in the troop clinics of the 1st and 3rd “Stryker” Brigades in the morning. This enabled soldiers to get on-site care, saving them much time, and also resulted in a good relationship with commanders in those units and appreciation for the skills PTs offer. I continued this practice during my time at MAMC (Madigan).

When the 3rd Brigade, 2nd Infantry Division was to be deployed overseas on November 2, 2003, ready for action in Operation Iraqi Freedom, the Brigade saw the need to take their physical therapist with them. Doctrine at the time placed PTs back at fixed-base medical facilities in the theater of operations. MAJ John Glorioso, Brigade Surgeon; BG Michael Dunn, Madigan Commander; and I as Chief of PT recognized the logic and importance of having a PT positioned directly with the troops. Quick access to PT would result in injury prevention, timely assessment and care with faster return to duty, and reduce exposure to dangerous IEDs positioned where military vehicles traveled.

MAJ Danny Jayne thus became the first physical therapist to be assigned to an Army combat brigade serving in combat. MAJ Brian Jovag became the second when he was assigned to Lewis’s 3rd Stryker Brigade Combat Team which deployed to Iraq in November 2003. The 81st BDE, a Washington National Guard unit, deployed to Iraq in March 2004. Noting the benefits of having a physical therapist embedded in the unit, they selected a reserve PT to accompany them. Doctrine finally caught up with reality, with PTs now regularly assigned to combat units throughout the Army.

A very inspirational and ground-breaking physical therapist was COL Mary “Sue” Ozburn. It was my great fortune that she was Chief of Physical Therapy at BAMC during my reserve years and upon my return to active duty in 1983. COL Oz was a very strong advocate for physical therapists being the initial evaluators for musculoskeletal problems.

COL “Oz” served as a US Army physical therapist for 30 years, serving two tours in Vietnam. She related that coming from an era where PTs were to follow the orders of physicians, she was once scolded for brazenly extending placement of a hot pack into the thoracic region when the physician had ordered this treatment for the low back.

Vietnam brought her the chance to use and develop her full skill set. She asked the orthopedist if he would like to see all the patients with low back pain rather than having her evaluate and treat them. His reply was one for the ages: “Not unless they are peeing uncontrollably on their drop foot brace.” Thus, direct access was fully endorsed in the combat zone.

COL Oz took the ball and ran with it, performing musculoskeletal evaluations and interventions with great success while she almost independently managed the care of soldiers and particularly civilians with thermal injuries. She related that there was a suggestion to amputate the arm of a Vietnamese man who had circumferential burns of an entire arm and forearm. She asked for a chance to see what she could do. Avoiding water immersion, a common practice of the day, she repetitively ran cool water over the limb and exposed it to sunlight, emphasizing frequent exercise to maintain full range of motion. The wound subsequently healed, function was maintained, and the man was eternally grateful.

Walking past a movie theater one evening, there was a sudden blast which injured surrounding military personnel and sent her forcibly to the ground, injuring her back. When the suggestion was made that she could be eligible for a purple heart, she wryly explained that she could never face her PT colleagues if she were given a purple heart for “back pain.”

As a LTC, she was assigned to Fort Jackson, SC during the time when basic training for males and females became integrated. She became concerned at the alarming number of training and overuse injuries the female troops were sustaining. Wanting to understand why, she obtained permission to disguise herself as a PVT (Army private) and went through the same basic training that the females experienced.

Her subsequent enlightenment resulted in training modifications that reduced the injury rate. Among them was a change in policy for troop formations. Rather than having troops positioned from tall to short when they marched, causing steps to exceed the regulation 30” length, the soldiers were positioned from short to tall, reducing the number of femoral and pelvic stress fractures. She noted that they moved just as quickly, only with a higher step turnover rate.

She also recognized that ill-fitting socks and female boots with a leather strap down the back which often buckled resulted in Achilles’ tendon injuries. Unfortunately, her excellent presentation of her basic training experience to my knowledge was not filmed or otherwise documented, but she has authored articles on her findings.

She was a strong proponent of physical therapists working to the top of their abilities, being physically active, and assertively claiming the role of musculoskeletal experts. I was honored to have served under her.

Winston Churchill famously stated: “To each there comes in their lifetime a special moment when they are figuratively tapped on the shoulder and offered the chance to do a very special thing, unique to them and fitted to their talents. What a tragedy if that moment finds them unprepared or unqualified for that which could have been their finest hour.”

When those daily or unique opportunities came along, the preparation and experiences I was granted enabled me to be prepared and qualified. I still think back in amazement of my opportunity to lead the first ever informational exchange between the medical departments of the US Army and the Republic of Colombia, a country that had been at war for 40 years! My hand-picked team with members of various medical specialties created a mutually beneficial training experience and set the stage for further productive exchanges.

Looking back on my military experience, I am thankful to have been with people who made me better--brilliant teachers, wonderful colleagues, the many patients who entrusted me with their care, and enlisted soldiers and NCOs who embodied the Army values and who taught me more than textbooks can offer. I was given many valuable teaching and continuing education opportunities, including the opportunity to obtain a PhD. I was helped to reach beyond what I considered my grasp into new challenges.

I am forever grateful that God gave me the opportunity to serve as an Army physical therapist.

Nancy E. Henderson



2LT Nancy Henderson in 1973 wearing the initial clinical uniform that the women all dreaded. How often we were mistaken for nurses! I wrote a poem about the more welcome and practical gold pant suit that replaced it.

At Camp Bullis, TX, during a field training exercise in basic training. The uniform was Vietnam era. I'm wearing the inferior quality boots that by design caused Achilles' tendon injuries.

8



TOP: I travelled from WA state down to Fort Sam Houston with two classmates Cathy Allsop and Barbara Long. We camped out and explored new territory along the way.

BOTTOM: This is our transition as we became 2LTs eager to begin our physical therapy training.



Many years later as a COL at Madigan testing the gluteal strength of a patient.

COL Tom Kurtz

Having grown up in a small Wisconsin town, I joined the local Army Reserve Unit which was an engineer battalion. During this time, I attended University of Wisconsin at Eau Claire and graduated in 1972 with a degree in psychology and sports medicine. My interest in athletic training started when I was in junior high school. I went on to earn a Master of Science in Physical Education from the University of Wisconsin La Crosse and got certified as an athletic trainer in 1974. I went active duty in the Army at that time as an athletic trainer and instructor at West Point. There I met Annie Webb who was the physical therapist at West Point and she helped to get me into the Baylor Army Physical Therapy program from which I graduated in 1978.

While studying at Baylor, I do not recall any specific training for direct access but the requisite was clearly drummed into us to evaluate each patient before starting care. At some point the leading Army PTs developed a program where therapists served as physician extenders to aid with physician shortages and enhance our value to the Army medical field.

I was assigned to FT Benjamin Harrison, IN where I taught at the Army Physical Fitness School while serving as chief of the clinic. Next I went to FT McClellan, AL where we did a lot screening and direct access at troop medical clinics and even did sick call in the clinic for all musculoskeletal injuries. It was my experience that direct access was partially dependent on the uniqueness of each facility and the personalities of each physical therapist.

In Heidelberg and at Ft Sill, though I wouldn't call it "direct access" the next door proximity to orthopedics made for a very close approximation with patients seen as soon as cleared of needing orthopedic intervention.

When assigned to basic training centers, therapists were a natural for physician extenders and direct access because of the large numbers of overuse injuries, sprains, and strains. In those situations therapists were given privileges to order and interpret X-rays and prescribe some medications and write profiles. As an example I recall a young woman in basic training who came in to sick call with hip pain. I ordered an x-ray, saw suspicious shadows, sent her right to orthopedics and her hip was pinned that next day because of a stress fracture. Stress fractures were not easily diagnosed with x rays because the radiographic changes were not always immediately seen. We would routinely see a patient with shin splints that turned out to be a stress fracture.

I enjoyed working with Annie Webb in Heidelberg and we laughed recognizing how important it is for a recommendation to physical therapy school to be made for only students with good potential.

I worked with Bob Boyles who started as a PT Tech and who went on to graduate from the Army Baylor program. He became a very good teacher and a real expert in manual therapy. Like most Army therapists, his skill as a diagnostician made him much more valuable in patient care than just providing treatments.

COL Jean Bryan Coe

I graduated from Mississippi State University in 1973 with a degree in biochemistry and secondary education. In 1974 I participated in the 6-week AMSC Army Junior Program at Fitzsimmons Army Hospital in Denver, which was a fantastic experience, with many valuable learning opportunities. An added bonus was that we actually got paid a little over minimum wage plus housing, and food were provided at no cost, which made this girl from Mississippi feel absolutely rich. Becky Storey Hooper was another future Army PT who benefitted from this Army Junior Program recruitment effort.

I started at the Army Baylor Program at the end of 1973. My professors were Mary Lucas, Annie Webb, Betty Landen, Sami Elberheri, Dory Sudduth, COL Beth Hamilton and Dr. Nelson. I do not recall any specific teaching about direct access care; however, my last clinical rotation was at Ft. Sill, OK which was one of the test sites for direct access Physical Therapy for soldiers with back and neck pain. Fortunately, my first duty assignment was also at FT Sill. The Chief was COL Rita Minogue but I mostly worked and learned a great deal from both CPT Rick Ritter and CPT Mike Smutok.

My next PCS took me to the military hospital in Okinawa where I stayed for 15 months (1976-1977). This tour was cut short when the hospital command was transferred to the US Navy. The silver lining was that I learned a great deal about the Navy and Navy Medicine. It was also fun to be a Captain in a Navy facility... it worked to my advantage on the phone... not so much in person.

Ft McPherson, GA was my next location; however, upon my arrival, I learned that the Friday before, the hospital had closed and the facility was now an Army Health Clinic. I found myself as the Chief of the one therapist clinic. After a few months, it became apparent that there was a funding problem for my position (no fund site on my orders), which resulted in new orders and a next day PCS to Ft. Gordon where I spent my mornings doing direct access PT at the troop medical clinic. COL Bobbie Davis was my Clinic Chief along with Sally McCandless as the assistant chief, Tom Jones, and Betty Dodd who graduated from the Army PT program in the late 1950s.

By this time, evaluate and treat meant much more than screening low back pain which brought a lot of additional responsibility without sufficient oversight. I evaluated one young soldier with hip pain. Turns out I totally missed the diagnosis. The next day I saw him limping down the road. Breaking a lot of rules, I stopped and gave him a ride to the hospital ER. The following day MAJ Tom Jones told me that on rounds, the Ortho doctor pointed out that the young PT had wisely brought him to the ER... what he didn't know was that I had missed the stress fracture which had progressed to a full fracture requiring surgical repair. I still think of that patient and wish I had not been so confident that his problem was just muscle weakness instead of a stress fracture.

I also recall being contacted by COL Ozburn at Ft. Jackson, who was very displeased about a patient with a pubic ramus stress fracture that I had misdiagnosed. Needless to say, I quickly learned more about diagnosis and management of stress fractures.

My active duty husband got an assignment to an ROTC position which did not have any Army PT opportunities for me. I left active duty in 1978, stayed in the Reserves and worked civilian home health. I studied at the University of Nevada, Reno and earned a master's degree in Communication in the Health Fields. My mother was not happy with choice of degree (what does that have to do with physical therapy?); however, the skills I gained were invaluable.

When my husband PCS'd to FT Bragg in 1981, the AMSC Assignments Officer, COL Carole Buss, called and asked if I would like to return to active duty. By then I was totally disenchanted with civilian physical therapy, and jumped at the chance. FT Bragg was an amazing

learning opportunity for me as a PT. Soldiers jumping out of airplanes on a regular basis taught me a great deal. There was no troop medical clinic duty here but the PT and Ortho clinics were beside each other and we had a back door entrance. The CO of the Orthopedic Clinic made it quite clear that PT was to see all patients complaining of back pain. In fact, he said on a regular basis, "Ortho doesn't want to see any LBP patients unless the patient was "peeing on his own drop foot". The new Battle Dress Uniform was the daily uniform. My husband insisted that I keep my boots shined so as to be able to see a reflection of two of my fingers. BDUs were not supposed to be ironed or starched. That edict lasted only a couple of months as the higher ups disliked the relaxed duffel bag dress fashion look. Thanks to my husband, my BDUs were also always starched and ironed at the post laundry. The starch was so heavy I had several patients sprain ankles as they "broke starch" putting their pants on.

In 1983 I had the opportunity to serve as Professional Fill with a Reserve Hospital Unit on the annual REFORGER Exercise to Germany. Initially they questioned (wondered), why the heck did they send us a physical therapist? There were no surgeries so no post op patients and I had no equipment; however, using only my hands, my brain and the occasional ice, I proved to the doubters that PT was a valuable addition to the unit.

In 1984, I was appointed to faculty for the Army-Baylor Master's Degree Physical Therapy program. In addition to teaching, I served as Class Advisor and was responsible for the Musculoskeletal Evaluation (MSE) Course. This course was designed for therapists working as direct access providers. Reservist COL Duane Saunders came and taught a large part of the two week program. I was happy that CAPTE (Commission on Accreditation in Physical Therapy Education) required all PT faculty members to have some clinic time which allowed me to see patients ½ day weekly in a troop medical clinic.

My boss, COL David Greathouse encouraged me to continue my education and get a doctoral degree. I accepted the encouragement and attended Colorado State University under Long Term Civilian Schooling. My degree was in Human Resource Development and Adult Learning. Again my mother thought that was a dumb idea, but that education/experience set me in a great place to later serve as Director of the Army-Baylor MPT Program. Graduating in 1992, my dissertation was a practice analysis and description of specialty practice of physical therapists working in business and industry.

Following graduation, I PCS'd to Brooke Army Medical Center, where I had the privilege of working for then COL Tom Jones, COL Ron Franklin and COL Gail Deyle. During that time, I taught part time in the Army Baylor MPT program and in 1995, I was assigned as the Program Director. I was blessed to work with a wonderful cadre of faculty. By this time, Direct Assess care was a large part of the program curriculum. Faced with a desk job in DC, I retired in 1999. I figured I was already on the mountain top and no other job was going to be as rewarding. I continued to teach part time in the program until 2008. The Program transitioned to a Doctoral Physical Therapy Program in Physical Therapy in 2005. The program was 18 months as a student at the Academy of Health Sciences, followed by a one year internship. The substantive change in the curriculum was focused more on direct access/primary care physical therapy, with increased emphasis on screening, systems review, diagnostic neuro imaging, pharmacology, and physical examination skills.

In 2006, I served as the lead agent in establishing a transition DPT program for all Army-Baylor MPT graduates. Members of the Steering Committee were Rebecca S. Hooper, PhD, MPT, Retired Chief of AMSC and prior MPT Faculty; Stephen Allison, PhD, MPT, Retired Army, Director MPT Program, 1999-2001; Robert Wainner, PhD, PT, Retired Air Force, Prior Faculty for MPT and DPT; and me.

The curriculum was based on a gap analysis between the Army-Baylor MPT curriculum 1992-2002 and the curriculum of the new Army-Baylor DPT program. This included course work as well as projects that were required during the DPT program final internship. Overarching tenets for the development of the curriculum were that it had to be taught all on line, there be no requirement for synchronous participation, and that there would be no requirement for group work. Later Baylor approved students with a Baylor MPT degree beginning in 1972 to participate in the t-DPT program. The program was designed for students who were working full time including those who may be deployed overseas. The program was two semesters long with 11 credit hours across 7 courses. Faculty were Stephen C. Allison, PT, PhD; Lawrence N. Masullo, MPT, MD; Michelle A Fritsch, PharmD; Robert C. Hall, DPT, MS, SCS; Jean M Bryan, PhD, DPT; and Stephen E. Folger, PhD, PT.

Realizing that students could not gain hands-on skills during on line courses, there were two Continuing Education Requirements students had to complete. One was a course in evidence based manipulation and the other was a course in evidence based medical screening. These courses had to be approved by the program director to meet the requirement. Additionally, students had to have a physician mentor to help them develop physical assessment skills in the Medical Differential Diagnosis for Primary Care Physical Therapists course. The first cohort began in May 2006 as part of the summer semester. There were eight cohorts of students between Summer 2006 and Summer 2009 for a total of 129 students. Of those, 25% were either deployed to Iraq/Afghanistan or assigned overseas. Sixty-five percent were still on Active Duty while the other 35% were enjoying a wide variety of civilian practice- including pediatrics, schools, private practice, hospice, hospital and acute care, outpatient, sports medicine, nursing homes, VA clinics, home health, women's health, as well as entrepreneurial fitness and health promotion programs.

On a personal note, the transition DPT Program was the most challenging, and most fun professional project I have ever worked on. In many ways it was a capstone experience for me in putting all my previous education and experiences, to work with a such a great group of people from the steering committee, to the Army PT Alumni Association, to the faculty and the students, to the support that I received from the Graduate School as well as from the Baylor staff. In a word, it was AWESOME!

Since retirement, I have continued to work in physical therapy. I am licensed in both Wyoming and Texas and enjoy the privilege of practice without referral. I currently have a part time pro bono clinic with my church. I have also served in both volunteer and paid positions in APTA including ABPTS, CAPTE and as a consultant in development and revalidation of multiple Descriptions of Specialty Practice, including four new, ABPTS recognized board certified specialties. I have also been fortunate to participate in seven medical mission trips, where, once

again, I have only my hands, my brain, my heart, and (occasionally...) ice. Those things, together with compassion and caring, go a long way toward making a real difference in a patient's life.

The giver always gets more than the receiver.

COL Rebecca Hooper

How "Evaluate and Treat" Became "Direct Access"

I attended Miami University in Ohio, planning to become a teacher, but my aspiration changed. I met LTC Tom Wheeler who was recruiting for the AMSC and I chose my new path.

My Army PT career began as a student in the US Army-Baylor University MPT program in August of 1974. Neuromusculoskeletal Evaluation (NMSE) by PTs was in its infancy. Early on during one of my half days in the clinic in the old BAMC basement, I distinctly remember being told to NOT do a McMurray's test on a knee patient because "the physician has already done that". It didn't make sense to me that we had been taught how to evaluate injuries if we weren't allowed to perform the tests!

I was fortunate that by the time I went to Reynolds Army Community Hospital at Fort Sill, OK for one of my affiliations, most of the consults for routine orthopedic injuries and complaints were sent directly to PT and read "Evaluate and Treat". A study of the impact of PTs doing musculoskeletal assessment on patients who had not yet been evaluated by a physician had proven that PTs were very good at serving as physician "extenders" at a time when many physicians were looking to exit the Army. Wonderfully skilled clinicians like MAJ Rick Ritter, MAJ Mary Huston, and CPT Jeannie Bryan shared their experience and expertise in becoming more confident in providing first line care.

Direct Access is often discussed only in terms of what physical therapy is done for the patient. But almost as important is how direct access can make sure that patients can be seen in a more timely manner in other clinics as well. This is facilitated by being allowed to order X-rays, some routine medications, and forward patients on for further evaluation if their care required something that was beyond the scope of PT. While most of the patients referred to PT were appropriate and able to be treated, I know all of us have a list of those patients we intercepted who had significant issues. I recall vividly the basic trainees who came on sick call with routine "complaints" but upon further evaluation, needed to be sent on. There was the young man who could not do an about face who turned out to have cerebral palsy, the trainee with neck pain from wearing his helmet who upon being X-rayed, had Klippel-Feil Syndrome, the back pain patient who had a broken Herrington Rod in place, and the kid with a dislocated shoulder from roughhousing in the barracks. These patients were immediately referred on and seen by the appropriate medical team with the history, films, and evolution already done.

While I was Chief of the Specialist Corps, 2000-2004, LTC Tim Flynn, the PT Program Director, came to me wanting to convert the program from a Master's Degree to an entry-level

Doctoral Degree. I had heard from others in the APTA accreditation world discussing this change and they believed it due based upon the number of hours in most of the programs and the expanding knowledge, skills, and abilities expected of a PT. To me, however, it was very important the degree granted was based on more than that. I told the program director that in order for me to support that move, the program had to demonstrate that it teaches and graduates a “better mousetrap”. That meant that rather than learning about NMSE in a short course taught AFTER graduation, students would study the imaging, pharmacology, evaluation and treatments necessary to be direct access providers immediately upon graduation. The redesign of the curriculum was enough to convince me that the DPT is the appropriate degree to be granted by the Army-Baylor PT Program.

COL Gail Deyle

In 1975, I earned a Bachelor of Science degree with a major in biology and psychology from University of Nebraska at Kearney after which I attended the Army Baylor Program and graduated with my MPT in 1977. Some years later, I went on to earn a DPT at Creighton University in 2001 and a Doctorate of Science from Andrews University in 2006.

When in the Baylor Program, I do not recall being taught the process of direct access. My instructors at Baylor included MAJ Ron Franklin who taught the clinical aspects of PT; COL Mary Lucas and Samuel Harry taught the basic sciences.

My first duty assignment was at Moncrief Army Hospital, FT Jackson, SC where I had the good fortune of serving under COL Sue Ozburn who was a true pioneer and advocate for direct access. Besides COL Ozburn, CPT Dan Guillotte closely reviewed my work. CPT Becky (Storey) Hooper was also there. Together, we saw hundreds of trainees daily. I was pleased that COL Ozburn thought I was a fast learner and I know I was fine with her scrutiny. I wanted to be a sponge to absorb and learn everything.

When at Ft Jackson, I found patients that did not belong in physical therapy including one person with a myocardial infarction. Another had ankylosing spondylitis and another had a pelvic tumor.

After FT Jackson, I served in Heidelberg and then Landstuhl West Germany and at both hospitals I was credentialed for advanced clinical practice privileges to include ordering musculoskeletal imaging, prescribing musculoskeletal medications, making inter-provider patient referrals and patient duty dispositions. All of my subsequent duty assignments allowed the same privileges of independent or primary care physical therapy.

I worked with COL Ron Franklin, COL Dave Greathouse and COL Dick Schreck to expand the depth and breadth of orthopedic physical therapy in the Army. In 1994 I endeavored with COL Ron Franklin to establish the US Army Orthopedic Residency program. We needed money for this to happen and we made a proposal to General Claypool who approved and funded our

program. After hearing from us, he exclaimed, "This is a no brainer!" . It cost \$10,000 per trainee. The BAMC residency started in 1995 and quickly became an APTA and the American Academy of Orthopaedic Manual Physical Therapists (AAOMPT) accredited doctoral (DSc Baylor) fellowship program with a strong emphasis on the clinical and diagnostic reasoning needed for direct access. It also provided a strong platform for musculoskeletal research published in top tier physical therapy and medical journals. See the appendix below.

To this day in 2023, I continue to teach as adjunct faculty for DPT and tDPT programs (transitional DPT programs are available to persons who earned PT degrees before the DPT was requisite).



COL Deyle teaching Baylor students.

COL Tim Flynn

I was on a 4-year Army ROTC scholarship as a PT student at Marquette University which paved my way into the AMSC upon graduation in 1983. I moved through the training at FT Sam Houston and was assigned to Brooke Army Medical Center. During my three years there I was fortunate to have several mentors, Jim Swain, Jim Heeter, Nancy Henderson, Jim Allie, Steve Stratton, Dave Greathouse, and of course COL Ozburn. After attending the NMSE Course I was credentialed as a Screener and did lots of direct access at the troop medical clinic. It was a tremendous learning experience where we routinely picked up fractures, tumors, and neurological disorders.

It was an interesting time because I was skyrocketing through scientific and clinical materials to solidify my skills for NMSE. My wife, also a PT, was working at Northeast Baptist Hospital as we only had one vehicle and it was within walking distance. Unfortunately, she was not afforded the same level of intense study and mentorship as I was.

It was great to attend neurosurgical rounds which were directed by LTC Jack Youngblood who was very supportive of PT and OT. We sat in the front. He ascribed to the belief that surgery was not the solution for all pain complaints. He told us that neurosurgery for low back pain is needed when a patient is urinating on his foot which could also be heard slapping on the floor.

Eventually, I earned my Master's degree in Biomechanics in the College of Osteopathic Medicine at Michigan State University in 1990. After completing my PhD at Penn State in Kinesiology in 1997 I returned to teach at the Army-Baylor PT program from 1997 to 2003. The last 2 years I was the program director. This was a time of tremendous research productivity by the Army-Baylor team and the new Orthopaedic Residency at BAMC. A number of the publications during this time changed the paradigm of management of musculoskeletal disorders throughout the country and the world. See the appendix below.

COL Andrea Crunkhorn

While attending Marquette University to earn my physical therapy degree, I also was enrolled in ROTC. Tim Flynn was a few years ahead of me at Marquette and he had no difficulty getting into the AMSC. Two other ROTC cadets were assigned to branches outside of the Army Medical Department the year before I graduated. One was assigned to Signal Corps, the other to Infantry. They both decided to join the Reserves and one of them, Christopher DeMeulenaere], was Brigade Commander of the 330th Medical Brigade, Ft. Sheridan, IL, before he retired.

Knowing this, I panicked. I took the advice to make connections with Army physical therapy clinics and get a clinical rotation at one. I contacted four clinics and was rebuffed until I reached out to Major Rick Ritter who was the Chief of Physical Therapy at West Point at the time. Also a

Marquette grad, he was gracious enough to let me spend six weeks on an orthopedic crash course as my last rotation before graduation. In many ways I owe my Army career to Rick.

After graduating in 1986 with my physical therapy degree, I did get assigned to the AMSC. I attended the Officer's Basic Course (OBC) in October and met Barb Ashby, the only other ROTC cadet to come on active duty that year. Following OBC, I was stationed at the 97th General Hospital in Frankfurt, West Germany. My first clinic chief was Kathy Nagel, another heaven sent opportunity as she was a former Army Baylor instructor. During my time there, I also worked with Jeremy Hutton and Megan Mills, then another great clinic chief, MAJ Joe Dettori. Because we were very busy all of our patients were referred; there was no opportunity for direct access.

After returning to the States and attending the Officer's Advanced Course I relocated to Camp Casey, South Korea in 1991. Being the only PT in 2nd Infantry Division (north of Seoul), I did a lot of direct access. Me, my one fantastic PT tech, and one KATUSA (Korean Augmentee to the US Army) were seeing about 1000 patients a month.

My next duty assignment was FT Sam Houston, TX as a recruiter. During this tour, I had the opportunity to work with LTC Jeannie Bryant at a Troop Medical Clinic seeing Basic Trainees.

I PCS'd to Sinai, Egypt where I served with the Multinational Force and Observers. With 6 medical doctors, myself and a PT tech we had a mix of referred and direct access patients. We served the northern Sinai at El Arish and in the south at Sharm El-Sheik.

After Egypt I went to Fitzsimmons as Assistant PT Chief. FAMC came out on the BRAC list (Base Realignment and Closure) almost the day I got my orders. I was there only 9 months and all of my patients were referred.

In 1996-1997, I was assigned to Walter Reed where I worked with COL Gil Sosa and LTC BJ Randolph for a year as the chief of outpatient orthopedics. That was mostly dependents and retirees, and was referral based care. Then I went for two years (1997-1999) to the Pentagon as an Executive Officer for the Assistant Surgeon General for Force Projection, where I worked for BG John Parker and then BG Kevin Kiley. I was able to spend a few days a month at the Pentagon Health Clinic; which had direct access as well as referred patients. While in this job I started a post graduate masters in physical therapy with University of Indianapolis, an excellent program that really consolidated a lot of what I had learned over the years through experience and talented leaders. I took an outstanding course from Bill Boissonnault on direct access, differential diagnosis and primary care screening.

Of note, BG Kiley and I had several discussions about direct access and where PTs should serve. He was a huge advocate of PTs in the line units. He came out to Fort Leavenworth while I was at my next assignment in residence at Command and General Staff College, 1999-2000. PTs serving in the brigades was a hot topic. He already thought we belonged at the battalion level. However, he also told me that Army PT needed to prove that we belonged far forward by obtaining hard data, preferably not obtained by ourselves. This was a very high bar as all of the data gathering platforms were focused on combat injuries/trauma, were not controlled by anyone

with a vested interest in our needs, that we could not easily access. At one point I did ask COL John Holcomb, Director of the ISR at the time, to add physical therapy to the database. That was a hard no. While we did gather some data downrange, and COL Joe Moore published an article on the impact of having physical therapy far forward (i.e., direct access), there was no slam dunk causal relationship established. We still need this data to solidify our gains.

I became the Chief at FT Benning where I served from 2000 to 2003. All of the staff rotated through all of the unit troop medical clinics as well as with the basic trainees. Care was a mixed bag of referrals (particularly at the hospital) and direct access. We also rotated weekend duty with the trainees on Saturday mornings. It was crazy. A line of 100 trainees would wind down the sidewalk waiting to come in. About half would turn left to the medical staff of six. Half would turn right to the PT clinic, with one PT and one tech. Those could be long days, and all of it was direct access. We caught plenty of cellulitis, many stress fractures, and occasionally something far more serious such as a deep vein thrombosis. There was a most unfortunate situation where a young trainee was referred with gastrocnemius pain and possible stress fracture. The PT was concerned for a deep vein thrombosis but other medical professionals ruled it out. Sadly, the patient died due to DVT. It was devastating to the staff who had seen him and advocated hard for the possibility it was a DVT. Differential diagnosis is as much art as science and we, the medical profession, do not always get it right. This really drove home the need for physicians to listen to the physical therapist working with the patient. We can see more through our more frequent contact and longer visits. Our voices need to be heard and respected.

Over the years, I remember seeing a patient referred by the emergency room for an ankle sprain. He was in such pain he could not sit still and he insisted that he never rolled his ankle. My examination indicated the problem was an acute compartment syndrome which I immediately referred to orthopedics. Their response was that my quick thinking saved this Soldier's leg. I recall another patient referred from the ER with low back pain. He looked ill, and on further examination in primary care, he was diagnosed with a kidney infection. Then there was the elderly gentleman also referred for acute back pain. On palpating his sacrum it felt very spongy and I went back through his medical history with his wife. He previously had cancer and sadly a referral proved metastasis.

After Benning, I was assigned to Madigan in 2003 where I replaced COL Nancy Henderson. There were PTs in the Special Forces unit and movement to put PTs in the Brigade Combat Teams; this was mostly direct access. The Madigan staff serviced the troop medical clinics and did a blend of direct access and referred care. In the hospital, we were very busy and had no time for direct access in that setting. With the onset of Operation Iraqi Freedom, we had a very short window for seeing any deploying Servicemember, with almost all of them coming to the clinic to be seen as walk-ins. We had a 72 hour window to get any SM (service member) appointment completed. As chief I almost exclusively did the knee and back classes plus walk-ins. On the weekends we came in sporadically to care for any units who were preparing to deploy, particularly Guard or Reserve. The military had a limited time window to determine if someone was deployable, and there were a number of Service members with chronic issues who were struggling with the physical training, body armor, marching, etc. There just wasn't enough time for their bodies to adapt to the significant increase in physical activity and stressors. For the Stryker brigades, another issue for the tall guys was sitting in a lot of lumbar and thoracic flexion

to fit inside the vehicle while weighted with body armor, ammo, a weapon, etc. We had one battalion commander who came home mid-tour and simply could not deploy again. He had managed his back issues for years but the deployed environment was too much.

The other major activity at Madigan was to prepare the 81st Stryker Brigade Combat Team medics to deploy. Many of these young men had graduated from medic school and gone home to do other jobs. Bob Matechjle was deputy chief and was a graduate from the BAMC orthopedic residency program. He designed and led a three week training program in basic musculoskeletal assessment and care.

I left MAMC for Air War College in Montgomery, AL in 2004; then in 2005 went back to Fort Sam as a combat developer to work with the Combat Doctrine Development group. Working with many of the previously deployed PTs, we crafted a set, kit and outfit that met strict size and weight restrictions while still providing a portable table that wouldn't flip during manipulations. In 2006 I got picked up for command at treatment clinic at Camp Zama, Japan. I did only a little care, mostly referral (although always a dash of direct access).

In 2007, while in command, I was selected as the Chief, Physical Therapy, Consultant to the Army Surgeon General, and Assistant Corps AMSC Corps Chief. This was really exciting and gave me an awesome opportunity to push for far forward care, direct access, physical therapy in the emergency room and primary care, and other initiatives started by superstars like Dave Greathouse and carried forward by my immediate predecessors, Chuck Scoville and Theresa Schneider.

In 2008 I went directly to Fort Leavenworth to command Munson Army Health Center, and again did only a bit of patient care, mostly referral, with a dash of direct access.

In 2010, I deployed as backfill to the 21st Combat Support Hospital which was engaged in dispersed operations across Iraq. I was assigned to Mosul but the American Forces were drawing down and we were not very busy. In a quick turn, I redeployed in February 2011 to the NATO Training Mission Command in Afghanistan as the Command Surgeon. This took me out of direct medical care as, despite connecting with the local medical clinic, they told me I was interfering with their cleaning schedule and they were not interested. All I could do was some sidewalk medicine- answering questions from friends and colleagues.

From Afghanistan, in 2012 I became Chief of Rehabilitation and Reintegration for OTSG and then AMSC Deputy Corps Chief. These positions took me out of patient care as I was also working on my transitional doctorate in physical therapy, but there were several key milestones achieved during those years for physical therapy. The Army Surgeon General, LTG Patty Horoho, had a vision to move the intersection of health, healthcare providers, and Soldiers from diagnosis after illness or injury more towards optimizing health and performance. This also came from the Army Chief of Staff's office. While at R2D (Rehabilitation and Reintegration Division) we conceptualized a Physical Performance Service Line to capture all things physical therapy and physical performance. In addition, then COL Teyhen was working over with the Performance Triad, which focused on sleep, nutrition and activity.

The battles we were fighting in the Corps office were manpower based, trying to resize our force structure. Direct access is always a goal, if not primary care, but I don't recall a major line of effort in the year I was Deputy Corps Chief. Over the years I saw that individual Medical Treatment Facilities (MTF) commanders, Deputy Commanders and others in the line of authority were empowered to stop direct access if they were uncomfortable with it. It required personal interaction, advocacy, confidence and establishing credibility in patient care, and it was easily lost when staff rotated. We have work to do to codify these practice patterns and get them into not just scope of practice but into other forms of regulation and policy that recognize PTs' role in direct access.

COL Christopher J. DeMeulenaere

COL Christopher J DeMelenaere is former President, CEO and Principle Owner of HealthReach Rehabilitation Services, Inc., located in Brookfield WI, where he also practiced as a licensed PT and managed a diverse staff of over 200 employees. As one of Wisconsin's largest Medicare Certified Rehabilitation Agencies, HealthReach provided skilled PT, OT and SLP services throughout the state to infants and people of all ages. COL DeMeulenaere graduated from Marquette University's PT Program in 1985 and eventually received an MBA from Cardinal Stritch University in 1994 and Ergonomic Certification from the University of Wisconsin, Milwaukee Industrial Engineering program in 2002. COL DeMeulenaere specializes in the treatment and prevention of Neuro-musculoskeletal Disorders (NMSD's). His civilian area of practice closely resembles his military role as a PT, namely to maintain a fit force, prevent disease non-battle injuries (D-NBI's) and provide immediate, effective and evidenced-based care when and where injuries do occur. After selling his private practice in 2019, COL DeMeulenaere continues to practice home-based PT with Rehab Resources, another therapist-owned Rehab Agency located in Wisconsin.

Marquette University and "The Warriors", as we were known back in the 1980's, definitely produced some of the finest PT's to serve and lead this nation and the SP Corps in a variety of roles. Colonel Timothy Flynn graduated in 1984, and after a 20 year active duty military career with multiple assignments, eventually retired from active service and owns a private practice in Colorado, specializing in advanced manual therapy skills for MSD's. Colonel DeMeulenaere graduated from the "Golden Eagle Battalion", as Marquette's AROTC program is now known, in 1985 and after 30 years of service in the USAR culminating in Brigade Command, he was the first PT and SP Corps Officer to ever command an Army Reserve Medical Brigade. Colonel Andrea Crunkhorn, a 1986 graduate of Marquette's PT program had an active duty career that spanned 30+ years culminating in being the Chief of the SP Corps. Undoubtedly, these 4-year AROTC Scholarship Cadets have made immeasurable sacrifices to lead the SP Corps from the front, advocating on behalf of the PT profession and the Corps to train, deploy and provide cutting edge, world class PT services whenever and wherever needed in the world. Furthermore, they were some of the first therapists to advocate for practice without referral nationally, embedding PT's into Combat Brigades to ensure a fit force and the prevention and treatment of

NMSD's as far forward on the battlefield as possible, as well as advocating for early detection and comprehensive treatment for the signature injuries of recent wars, namely TBI's and PTSD. The Jesuits at Marquette University fully embraced educating the Citizen-Soldier, as Father Zepps, who taught Military History and the Art of Warfare to the AROTC Cadets at the time, recognized moral decisions need to be made on the battlefield every day. We are forever indebted to the higher learning institutions including our Military Academies that educate and train some of our greatest leaders!

In greater detail, COL DeMeulenaere initiated his military career as an AROTC Cadet while attending Marquette University from 1981-1985, as a 4 year scholarship awardee. He received his commission in the United States Army Reserve (USAR) on May 18, 1985, where he was assigned to the 452d General Hospital (GH) as the Assistant Supply Officer. As the 452d GH transformed into a Combat Support Hospital (CSH), with the advent of Deployable Medical Systems (DEPMEDS), his role became more clinical. He advanced from a skilled, manual Physical Therapist with neuro-musculoskeletal training provided by COL Duane Saunders and his team, to eventually become the Chief of the Rehabilitation Section and finally to the Chief of Professional Services for the Hospital, with additional duties of Safety Officer and Antiterrorism Officer. In 2007, he was selected as the SP Corps Advisor at AR-MEDCOM – ARMY RESERVE MEDICAL COMMAND - , ensuring a validated and capable SP Corps, preparing SP soldiers for mobilization and deployment. In 2009, COL DeMeulenaere was selected as Chairman of the Army Reserve Credentialing Advisory Panel (ARCAP), which oversees credentialing for all AMEDD officers in the USAR as required and authorized under the Army Professional Management Command (APMC). He later transferred back to the 452d CSH to serve as Deputy Chief of Clinical Services as well as Battalion (BTN) Executive Officer, prior to transferring to the 1207th USAH (attached to the APMC) in Ft. Benning, GA and being selected on the COL Command Board as the 330th Medical Brigade Commander. During his career, he has been mobilized in CONUS in support of OEF - Operation Enduring Freedom - as a Physical Therapist/Safety Officer, and has provided medical support Outside Continental United States (OCONUS) both in Ecuador and Paraguay through US-SOUTHCOM (Southern Command). The 330th Medical Brigade, located in Fort Sheridan, IL, oversaw 2 Combat Support Hospitals and a Multifunctional Medical Battalion, as well as 22 Company sized elements, during COL DeMeulenaere's tenure. They were primarily responsible for all medical deployments in the USAR from 2013 through 2015, as well as a homeland defense mission for their ground ambulance assets. The 330th Medical Brigade was comprised of over 2,200 Soldiers in 8 states at the time of COL DeMeulenaere's command.

After a 30 year career in the USAR, there are a few lessons today's SP Corps Officers could learn from some of the prior SP Corps Leadership. First, hone your skills as a highly skilled, tactically and technically proficient, medical professional early in your career. Mid-career, don't hesitate to take risks and explore broadening assignments to expand your skillset- leadership requires much more than manual therapy skills alone. Finally, if you are fortunate enough to explore the senior leadership roles and responsibilities, don't hesitate to reach for the stars- literally and figuratively! The SP Corps has been honored most recently with its first active duty General Officer, namely BG Deydre S Teyhen, a well-deserved honor for our Corps and for BG Teyhen, who will lead us into the future. Finally, don't hesitate to consider all of the options of exploring your career as a full time SP Corps Officer or transitioning to a Citizen-Soldier, where

you can explore your career further on the civilian side, while still maintaining your allegiance to Armed Forces in the USAR or ANG. You have many options, including the Public Health Corps, where your skills are highly needed and you can still serve our Great Nation. On behalf of a Grateful Nation, good luck with your career and don't ever hesitate to reach out to current or retired SP Corps Leaders, who are more than willing to continue to mentor, coach, train and teach the future leaders of the SP Corps!

Tracy A. Smith, LTC, USA (ret)

From Direct Access to War

In January 1991 and I was waitressing at a lobster house in San Diego CA. I had just been accepted into the US Army Baylor Master's Degree in Physical Therapy (PT) and had 3 months before I would enter on active duty as a 2LT. It was slow that day and the bartender motioned me over "Hey, Tracy didn't you just join the military? You should see this". And there it was on CNN. The American Navy was launching SCUD missiles off the deck of the USS Missouri into Iraq. The Gulf War had just begun and everything about me becoming an Army physical therapist had just changed.

I graduated from Army Baylor PT school in 1993. After PT school and as soon as I was allowed to, I attended the COL Doug Kersey NMSE Course. It was there that I honed my skills how to read Xrays, order MRIs, bone scans and prescribe minor pain medications. I remember feeling more confident in treating soldiers via direct access after attending the 2 week course. The doctors sent anything that wasn't a cold or a flu directly to the PT and we loved it. We saw freshly sprained ankles, ACL tears, and shoulder dislocations, often immediately after they happened. My first duty station was Ft Belvoir and then later the 25th Infantry Division (Light) at Schofield Barracks. I had several great bosses (COL Zurawel, CPT Christina Gallagher, CPT Shannon Lynch) who encouraged me to attend Army courses and really learn about being, not just an Army PT, but an Army officer. I will forever be grateful for that support and advice.

I passed Air Assault school and Expert Field Medic Badge training, which were not only great training but also earned me some credibility with my patients, the "real Soldiers". I was learning to love being a Soldier. I loved the collegial relationship PT's had with our PA's and Ortho doctors. Direct Access was the Army PT's badge of honor, and none of us could imagine practicing physical therapy without it.

I was fortunate to be selected to attend school for my Doctor of Science and an Orthopedic Fellowship at Baylor. Direct access was a given, and now I was also trained to work on complicated cases and teach entry level doctorate PTs. The Army had given me so many opportunities to grow as a PT, and as a person. I was a world away from that young waitress in the San Diego lobster house. And then the call came.

In January 2007, and I had just finished my Fellowship. Operation Iraqi Freedom had been going on for 3 years. The Chief of BAMC Physical Therapy, COL Zurawel called me into her office. "Tracy, I've been tasked to supply a PROFIS PT to Ft Riley. They are deploying to Iraq in April and they need a PT. You'll be leaving for Forward Operating Base (FOB) Falcon,

Iraq in 3 months”. I called my husband. Our daughter had just turned 5 a few months earlier. “This is going to be the hardest thing I have ever done.” I remember thinking to myself.

I knew that I needed to be prepared for everything and anything. I was going to a small, level 2 aide station 20 miles outside the green zone. For the year that I was there I would rely extremely heavily on my direct access experience, and everything I had ever learned about neuromusculoskeletal conditions plus some. I was grateful for the time I had spent training in the ortho clinic to learn casting, bracing and joint injections. I had also tried to memorize as much emergency medicine as I could get my hands on. I was nervous but I tried not to show it.

Looking back now, I know that for everything I gave up that year away, I gained more. More perspective on our military, more understanding of what camaraderie is, the darkly funny things that happen in a combat zone, the nature of mankind, the goodness of people, the self-worth that can only be earned, not given, the understanding of what ‘hard’ really is, and the understanding of how incredibly blessed Americans are.

When I think back on that year, I know that it was only because of my thorough, intense training as an Army PT and musculoskeletal screener that I was able to serve my soldiers well that year. I kept a detailed journal that year and have been writing some of those stories into actual story format. I’d like to share part of one of them as I feel it summarizes the role that so many Army PTs play in a combat setting. I don’t pretend to speak for anyone else but me. However, after “talking story” with many of my battle buddies I feel there is a common thread for us all. I hope it is helpful for those who wonder about life as a medical officer in war.

Understanding What it is to be a Soldier:

I headed to the Troop Medical Clinic, where I would work for the next year. Sandbags were stacked high, covering every inch of the building windows. Massive artillery rounds were firing from base and I could hear small arms fire going off in the distant city. The surreal sounds that made me jump didn’t seem to make any impression on the line of soldiers waiting for me outside the clinic. Most of them were sweaty and dirty and all of them looked tired.

I made my little 15 x 15 plywood clinic into a haven as much as possible that year. I wrapped white Christmas lights around the ceiling and played John Maher’s 3rd album Continuum on a loop. I tried to create a place where my soldiers could put their memories away for just a little while. I wanted to remind them that kindness and healing still exist.

On the other hand I was also trying to adapt to their world. To stop jumping when I heard gunfire while brushing my teeth, or seeing soldiers in the laundry line with filthy uniforms but clean, well-cared-for weapons. Some things I never got used to seeing.

Like HUMVEEs with gunshot cracked windows, or enemy POWs in blindfolds with hands tied behind their backs while I walked to work. Some people never adjust to life here. Rumors floated around the clinic about the mental health officer who was sent home for “failure to adapt”. My life became about getting soldiers better so they could go back out into "sector" and risk their lives again, about reading X Rays and putting on casts and making decisions on which injuries were serious enough to evacuate back to the Green Zone, or home or not. The doc's looked to me to make the call on any musculoskeletal injury that might take a Soldier out of the fight. I was the only physical therapist on a FOB of 8,000 Soldiers. Patch them up and keep them fighting. Believe it or not it's almost always what they wanted, too.

Like SPC Brown. He was an infantry soldier who I treated my first month there. He had just returned from Walter Reed hospital where he had been evacuated 4 months earlier. A rocket tore a hole through his HumVee killing his commander and ripping off the top 2 muscles of his right quad. They reconstructed it and then somehow he faked his way out of the hospital saying he was “good”. And they let him return!. He walked with a limp and his leg strength was terrible. There was no way he should have been back here. But he very happily told me how he tricked the doctor into letting him come back. “My unit needs me ma’am” he told me. My jaw just dropped. Who are these men that I treat day in and day out? These men who fight wars, who think war, who dream war, who ask to return to war. Their bodies are injured with broken bones and broken flesh but clearly they are not broken in spirit. Maybe they are simply fearless, or they just hate fear and so try to conquer it. I do know they come back for their brothers in arms, their battle buddies. And it must be a bond that is so strong that it overrides the rational fear of dying in this dirty, old place, where the dust is older than The U.S Constitution. They trick their doctors Stateside and wind up in my clinic asking me to patch them up so they can fight with their unit once more.

“He shouldn’t be here” I thought to myself. I asked SPC Brown, “Did anyone test if you’re able to run? Hop? Jump? “. “No ma’am” he says. “I just told them it didn’t hurt anymore and I wanted to come back”.

I can’t comprehend what drives him. But I do not believe it’s hate. I am quite sure it isn’t hate. From what I have seen this type of Soldier is rarely the outwardly macho type. They come in all shapes and sizes. They are often quiet, sometimes intense, and always very respectful. They are rarely the “hooah” ones who boast and call attention to themselves. These men just soldier on. And on. And on.

Day after day I treated them. My Soldiers. The same kind of soldiers I had treated in my stateside clinic. But here, I was in THEIR world. Sure, I could work on their necks and knees, and I did with all my power. But they manned the guard towers that kept me safe, they traveled on convoys to protect me, in case we were attacked. They came into the TMC with blood on their uniforms, telling me they were late for their PT appointment because their convoy had been in an IED attack. I watched them work day and night in the harshest place on the planet. For a while, I felt embarrassed that I carried the same title they did – I felt unworthy of the word “soldier.” A few jokes here and there that my uniform looked a lot cleaner than my weapon. But by the end of my deployment, it became clear to me that my mission was taking care of them and they didn’t expect or even want me to be like them. But I’m incredibly proud to have tried, even if just for a little while.

Going home was difficult. Leaving my patients, and parting with my medical team was like leaving my family all over again. Even worse in some ways. Life that year was reduced to the most vital, the most essential bits and pieces of being human that I can think of. It seems to me like that year of my life is in color and everything else is in black and white. I remember it so vividly. I had a front row seat watching the best and the worst of man. Perhaps the true essence of man in the rawest form that exists. Surviving. I don’t ever want to be back in a war zone, it was an awful year. But I don’t regret it either. And I would do it again. For all the terrible things that happened while I was there, I would still do it again.



FOB Falcon Troop Medical Clinic (TMC) crew. I am in the turquoise scrubs in the center



Carrying a Soldier to the helicopter



Ssg Eddy (PT Tech) & me outside TMC

BG Deydre Teyhen

On July 8, 2022, COL Deydre Teyhen, the 20th Army Medical Specialist Corps (SP) Chief made history by being the first active duty Army physical therapist to be promoted to the rank of brigadier general. With this promotion she became Commander, Brooke Army Medical Center (BAMC) and Deputy Market Director, San Antonio Market, Joint Base San Antonio.

Her journey began at Ohio Wesleyan University and while earning a BA in Sports Science, she started to search for physical therapy schools. She chose the U.S. Army-Baylor University

Graduate Program in Physical Therapy because she could study physical therapy and serve her country. “I also fell in love with the direct access the Army had at the time, which includes being able to order imaging and appropriate pharmaceuticals, and being able to do referrals – that was all intriguing to me.” (APTA 2021).

After graduating from the U.S. Army-Baylor University Graduate Program in Physical Therapy Program, she worked as a staff PT. A photo of a younger CPT Teyhen serving in Bosnia 1996-97 can be seen in Greathouse, Young, Shaffer (2021). She earned her PhD in biomechanics at the University of Texas and returned to teach at her physical therapy alma mater. Her stellar pedagogic skills were acknowledged by receiving the prestigious Margaret L. Moore Award for Outstanding New Academic Faculty Member in 2008. The following year she departed from the U.S Army- Baylor University Doctoral Program in Physical Therapy and was assigned as a clinician to Al-Kut, Iraq but was re-directed and became the officer-in-charge (OIC) of Task Force 10 Delta Med (APTA 2021; DVIDS 2022) – a significantly important command position.

During her exemplary career, BG Teyhen had numerous Army Medical Department commands, including Commander U.S. Army Public Health Command, FT Sam Houston, TX; Commander U.S. Army Health Clinic Schofield Barracks, HI; Assistant Chief of Staff for Public Health Office of the Army Surgeon General; and Commander of the Walter Reed Army Institute of Research (WRAIR). Due to her outstanding performance of duty as Commander of WRAIR, she was chosen for a crucial role in Operation Warp Speed, the program to accelerate the development, production and distribution of Covid-19 vaccines, therapeutics and diagnostics. She also served as the DOD’s Lead of Therapeutics at the US Department of Health and Human Services.

In August 2023, BG Teyhen became the Director, Defense Health Network National Capital Region for the Defense Health Agency. This Director position is responsible for more than 12,000 staff personnel in 34 medical and 11 dental facilities (Health.mil 2024). Obviously, she wears many hats!

*Editorial Comment: General Teyhen picked the Army Baylor Physical Therapy Program to serve her country and to provide care with “direct access”. In her command positions she uses those same skills. “What’s exciting now is to really be able to create an environment for clinicians to excel and really help soldiers and their family members” (APTA 2021). **From whence we have come?***

IN CONCLUSION

THE EVOLUTION of DIRECT ACCESS: WHAT MIGHT HAVE BEEN HAPPENING?

There are no succinct dates or a promulgation when direct access happened. Quite possibly, the glacial creep started more than a century ago with the rising interest in gymnastics and promotion of healthy movement of humans (Ling; Terlouw 2007; Quin 2017; Wanneberg 2018). Clearly polio and wars gave rise to the science of physical therapy. Army orthopedists, Dr. Goldthwait, quoted above (1921) and Dr. Granger, writing in *The P.T. Review* (1923) definitely recognized the importance and uniqueness of physical therapy. Granger stated that the care to soldiers rendered by the physiotherapists demonstrated that this medical discipline was essential not only to the Army; but also the Navy, Public Health, Veteran's Bureau and civilian hospitals.

The war in Vietnam was the final impetus to direct access of physical therapy because of the shortage of doctors, especially orthopedists. Greathouse et al (1994) noted that non-surgical patients with musculoskeletal problems did not get care quickly until this change in access took place. Physical therapists became physician extenders as told above in some of the oral histories.

Direct access in the military to physical therapy has proven to be effective and safe (Moore et al 2005) and it facilitates care (Greathouse et al 2021; Szymanek et al 2022). It is important to note that the Army established safeguards through regulations, designated physician supervision, required credentials and courses in neuromusculoskeletal evaluation (Greathouse et al 1994; Benson et al 1995). Also, see COL Metcalf's comments above and the editorial statement at the end of COL Duane Saunders's oral history.

The movement to physician extender occurred not only in the Army. As noted by Bill Bracewell above, on his affiliation as a student at the USPHS in New Orleans, he learned the independence of physical therapy. With multiple communications I have learned that the evolution of USPHS to direct access was parallel to the Army. Dr. Steve Wolf, a former USPHS provider 1966-1968 always felt "evaluate and treat" was the only order. "When this startling revelation greeted me on my first day as a practicing PT, and I inquired about where I could find the script, the response I got uniformly from the docs was 'aren't you a PT? You should know what to do!' This was the attitude at all USPHS Hospitals across the country. I considered myself very spoiled. In fact, medical residents would come to observe our treatments and asked questions" (personal communication).

Dr. Martha Nelson, wife of Dr. Roger Nelson agreed with this understanding. CAPT Charles L. McGarvey and CAPT David Nestor corroborated that Dr. Roger and his brother Dr. Arthur Nelson, both PTs with the USPHS were strong proponents for direct access to physical therapy (personal communication). CAPT Jeff Richardson and LCDR Kevin Healy in personal communications indicated that 1972 is when the USPHS formally confirmed that PTs could evaluate patients with musculoskeletal injuries without a physician's referral.

Additionally, this evolving role of physical therapists offered great benefits to the civilian community with cost savings (Mitchell and de Lissovoy 1997). It is safe (Boissonnault et al 2010; Basore 2010; Moore et al, 2005) but underutilized (Clark et al 2022). The APTA advocated for direct access (Massey 2002). In 2005, Medicare approved direct access to

physical therapy with some restrictions and as determined by individual state laws (APTA 2020 b). Internationally, the World Confederation of Physical Therapy reports that over 70% of the member countries have some form of direct access depending on the type of payer (WCPT 2023).

As stated by Weisz (2003), “Specialization appears in many ways to be a self-evident necessity of medical science whose existence requires little explanation.” Physical therapy is a special component of the medical science for the care of patients. Surgery or medication is not always the best or only answer for all maladies and neither is physical therapy. In many cases surgery or medication is the best treatment approach; but, physical therapy is essential in conjunction with those interventions and should be a core part of the health care system. The mis-management of patient care is not expanded by access to physical therapy. Health care can be improved by direct access to physical therapy (Greathouse et al 2021; Moore et al 2005) and the cost to the medical system may be reduced (Mitchell and de Lissovoy 1997; Clark et al 2022).

History is easy to write with dates, facts and numbers, but recording and reporting on the perspectives of individuals who lived and made it, is difficult, yet essential. Oral histories provide the human experiences; but, when gathered years after the events, memories and exact details may not be perfect. Nonetheless, they are important.

It has been an absolute joy and enhancement to my life to talk with these dedicated veterans and to hear their experiences. Their dedication to our country, profession and our patients exemplifies the goodness of humankind.

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Appendix of peer-reviewed articles from the Army Baylor Doctoral Fellowship in Orthopedic Manual Physical Therapy from 2000 to 2022. Compiled by COL Gail Deyle.

Peer Reviewed Publications:

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