physical therapist for the future are more important.

Unfortunately, I feel that many people have not honestly evaluated their motives in gaining entry into DPT programs. I could not agree more with your remarks on the "advanced DPT" (God forbid!) and the ramifications for faculty development. I hope that physical therapists everywhere will read your editorials and see the logic in your thinking. Then we can move ahead as a profession and continue to train the highest-caliber physical therapists, regardless of titles.

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DPT: Is the Missing Link Still Missing?

To the Editor:

I read with interest your recent Editor's Note entitled "Education at the Crossroads: For Today's Practice, the DPT". Even though I have never been in academia, I have had a sincere and abiding interest in the educational preparation of physical therapists. And, at every opportunity, I have seen fit to involve myself in the dialogue of how physical therapists should be prepared to enter practice.

Early in my career, I recognized that something of substance was missing from the manner in which physical therapists were prepared to enter practice, and that no matter how much we tinkered with developing entry-level models, that "something" was still missing. Each of the models advanced through the certificate, baccalaureate, postbaccalaureate, and now the DPT were intended to better prepare the student to effectively deal with the requirements of practice at that point in time. Along the way, we have had critics of each one of these models, and, as you correctly identified, the postbaccalaureate program was not fulfilling its objectives.

Now, we are pursuing yet another avenue, which many in academia feel confident will result in the development of a practitioner who, in every way, will be better prepared to meet the demands of our markedly expanding scope of practice...but will it?

I believe it will not, because the missing link I referred to earlier is still missing. Let me explain. We all know of master clinicians who have entered the profession from every level of preparation we had to offer, whether they came from certificate, baccalaureate, or master’s degree programs. How can we explain this in order to capture those essential qualities or behaviors needed to prepare such an individual? Will the DPT program ensure a greater proportion of similarly competent practitioners?

The extent to which the didactic education of students contributes to this desired level of preparation has never, in my opinion, been quantified. I would certainly prefer that students as a group demonstrate maturity beyond their years, have an understanding of life itself before being asked to deal with the abnormalities of the living, be well grounded in the sciences of our profession, be ambitious, and so on. I'm certain that these qualities, among others that I have failed to mention, are evident in varying degrees in many of our graduates, but these attributes alone will not ensure the end product we all desire for our graduating students.

I believe the answer rests primarily in how we approach the clinical education of students, regardless of the degree we confer upon them. Simply stated, students cannot become outstanding clinicians unless they are afforded a comprehensive opportunity to "practice" in an environment where skills can be applied and perfected—a setting wherein theory and practice come together and complement one another to cause the science and art of physical therapy to join as one. This is how superb clinicians will be created.

There are many obstacles in the path of bringing such a concept into reality. Nevertheless, medicine has succeeded, and clinical internships in medicine are almost as old as the profession itself. Proliferation of our education programs combined with the diminishing number of clinical education sites has had an undesirable effect on a program already beset with numerous logistical and financial problems. I believe these impediments can and must be overcome, especially now that we are reaching the pinnacle of academic preparation, but solutions are still lacking in this essential aspect of student preparation. This may require substantial change for both academia and our clinics, and a major adjustment in the way business as usual is conducted.

I have heard of various propositions over the years for strengthening our clinical education programs, but there has not been a well-organized or coordinated effort to gain consensus and acceptance of these proposals. For that reason, I was excited to learn that the Association will be conducting the Consensus Conference on Clinical Education in November of this year.

My hope is that something positive will evolve from this conference and that we no longer will attempt to resolve this issue by postponement, but through honest and thoughtful debate. We must seize this opportunity now to ensure the integrity of our education and clinical education programs for the benefit of the patients we are called upon to serve.

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Editor's Response

As a former president of our Association, a Mary McMillan lecturer, a Catherine Worthingham Fellow, a founder of APTA's Private Practice Section, and the first president of the Foundation for Physical Therapy Research, Mr Magistro brings an extraordinary perspective when he talks about practice and education. He and I do not differ on the essential point: No matter what degree is offered, we must expect graduates to perform better clinically than they do now. I believe, however, that there is an underlying misconception beneath Mr Magistro's concerns as they relate to the DPT. Clinical education and preparation for clinical interactions are a rarely studied part of our profession's education programs. I agree that we have had a missing link—but I believe that is exactly why the DPT is needed.

Current overcredited programs append clinical education as best they can, and that is not the way we should prepare problem-solving, skill-rich practitioners for today's health care arena. The
constraints of current programs make innovations in clinical education difficult, if not impossible. Properly constituted DPT programs, however, can allow for appropriate course sequencing, integration of practice and theory, and clinical work that should lead to better-prepared clinicians than we have ever seen before. In addition, only in education programs that are properly structured can new physical therapists learn how to use evidence to bridge the gap between theory, didactic education, and practice. Does the DPT guarantee bridging the gap that Mr Magistro warns us about? No, but it does more than any other model of physical therapist education: It gives us the opportunity to do it right. The DPT should not be about changing didactic education, but about reformulating the educational preparation of new physical therapists—including preparation in the clinical setting.

Jules M Rothstein, PhD, PT, FAPTA
Editor

Outcomes Research in Acute Care Settings

To the Editor:
I just finished reading with interest the report by Roach et al entitled “The Relationship Between Duration of Physical Therapy Services in the Acute Care Setting and Change in Functional Status in Patients With Lower-Extremity Orthopedic Problems” in the January 1998 issue. I agree with authors that more outcome research is needed in acute care settings, using standardized tools. I commend the authors for their research.

The authors refer to a study by Van Dillen and Roach1 and state that the Acute Care Index of Function (ACIF) has established reliability and validity in an acute care setting. The authors fail to mention that the study by Van Dillen and Roach was completed on a neurological case mix to the exclusion of other types of conditions.

The inferential leap from neurological to orthopedic conditions is tenuous. I believe the ACIF needs to have formal investigation of reliability and validity in a case mix that is representative of an acute care department. I work in an acute care setting, where a variety of service lines are seen by both occupational therapists and physical therapists. The percentage of referrals tends to be high in the medicine, surgery, and trauma units.

I am a senior physical therapist student at Neumann College in Aston, Pa, and I am completing my research project. The purpose of my research is to test the interrater and intrarater reliability of measurements obtained with the ACIF in a general population of patients in an acute care department. I decided to test interrater and intrarater reliability on a random sample of all patients treated, instead of focusing on a particular patient population.

I believe the authors were able to bring many thought-provoking questions to light concerning outcomes research in the acute care setting.

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References

Author’s Response:
Sabina Kapasi is to be commended for her understanding of measurement and her willingness to answer important questions about measurement tools by doing clinical research. She is absolutely correct in asserting that the reliability and validity of a measurement tool is relative to the population in which it is used.

The study reported in our article was a retrospective cohort study using existing medical records. The physical therapist staff involved in the study had decided to use the Acute Care Index of Function (ACIF) as a standardized functional assessment for clinical purposes. Prior to making the decision to use the ACIF, they conducted an informal examination of its validity in their setting by reproducing some of the original validity study.

They also conducted training and practice sessions with the ACIF to ensure it was being used reliably. Although these sessions served to assure the clinicians that the ACIF was appropriate for use in their setting, their informal examination of validity did not produce a research article that could contribute to our body of knowledge in this area. Ms Kapasi’s research will be a valuable contribution to our literature. I wish her well in this endeavor.

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Challenging Assumptions

To the Editor:
I was concerned about some of the assumptions made and conclusions drawn in the research report titled “The Relationship Between Lumbar Spine Load and Muscle Activity During Extensor Exercises” by Callaghan et al in the January 1998 issue of Physical Therapy.

It appeared that a major assumption embraced by the authors was that increased muscle use and spinal loading are harmful. This assumption led to their conclusive statement, “Although commonly used in rehabilitation protocols, the exercises involving trunk extension (the prone press-up) require very high muscle activity levels and resulted in substantial joint loads, suggesting that their use is unwise.” It is disturbing that this statement would be printed without a challenge by the Physical Therapy Editorial Board.

First, the term “prone press-up” is used incorrectly. The authors’ article discusses active lumbar extension strengthening exercises. The prone press-up is, in fact, a passive lumbar press-up that is performed by raising the head and trunk off the floor primarily using the power of the arms, not the lumbar extensors.

Second, it could be argued that strenuous muscle use and joint loading are well-known rehabilitation techniques, not activities to be avoided. In fact, one goal of the sports medicine and industrial rehabilitation therapist is to reha-