As a physical therapist/athletic trainer, I work in a physician-owned sports medicine clinic, the Idaho Sports Medicine Institute (ISMI). It is located on the campus of Boise State University, a 1-A university of 15,000 students. We work with a variety of athletes—university, recreational, youth, masters, semi-pro, professional, and Olympic—who represent a wide range of abilities.

The Setting

Our athletes play football and rugby. They racewalk, kayak, and rock climb. They fight fires, ski on Alpine skis, telemark skis, cross-country, and water skis. They speedskate, figure skate, perform in the ballet, bull and bronc ride in rodeos, bike race, and road race. They play basketball, racquetball, tennis, soccer, softball, and participate in a myriad of other sports.

As with many sports medicine centers (Olsen, 1996), most of our patients are high school or recreational athletes. Because of our affiliation with Boise State University, however, we do see a high percentage of scholarship-level university athletes.

We have a team of professionals assembled at ISMI: 3 orthopedic surgeons, 2 physical therapists (one is also an ATC), 6 ATCs, 2 exercise physiologists, 2 X-ray technicians, and 6 office staffers. Other sports medicine clinics across the country have a slightly different staffing pattern. While 90% have physical therapists and 60% have certified athletic trainers, fewer have physicians, exercise physiologists, and X-ray technicians (Olsen, 1996).

In addition, our office usually has at least one physician in a sports medicine residency or fellowship. And we often have physical therapy, athletic training, and exercise physiology students doing internships for varying periods of time.

Our clinic operates on a third-party payer basis; occasionally we work with first-party payers. We generally do not work with Medicare, workman’s compensation, or third-party litigation. We are beginning to deal with managed care and participate in several HMOs and MCOs.

A survey by Olsen (1996) revealed that 73% of the sports medicine centers had some managed care contracts, most involving less than 25% of the total business. We fall within those parameters currently, so we have not yet experienced the full implications of managed care. But like many others, we have seen some of the effects, including limits on payment for physical therapy and other services, limits on the number of visits allowed and types of treatment covered, and requirements for outcome justification (Monahan, 1993).

Our clinic provides outreach services to several organizations in the community, in the form of physician services, athletic therapy services, speaking engagements, event coverage for high schools, club sports, rodeos, bicycle races, and professional and semiprofessional organizations.

Most other sports medicine clinics also offer this type of service (Arnold et al., 1996; Cormier et al., 1993; Duncan & Wright, 1992; Morin, 1992; Nass, 1992; Olsen, 1996; Sexton et al., 1994) and approach it as we do. In other words, some of the services are provided on a contractual basis but much of it is seen as a public service, or a contribution to the community.
Background

I am a sports certified physical therapist and a certified and registered athletic trainer. Actually I started out as an education major and taught high school, then later worked in child welfare and social services before getting into physical therapy. I earned a physical therapy degree at Northern Arizona University in 1981 and practiced PT for nearly 7 years before returning to school to get a master’s in exercise science.

I took the internship route to become an athletic trainer. I had been working in ski towns, hospitals, and clinics and realized that if I really wanted to do sports medicine well, I needed to be an athletic trainer as well as a PT. The ATCs were getting all the “fun” patients, and I could see that the athletes trusted the ATCs and were more comfortable with them than with PTs.

Athletic trainers knew things I didn’t know—like how to evaluate and treat acute injuries, how to prepare athletes to return to sports, and how to treat ankle sprains, for example. I wanted to know how to do those things as well as I knew how to do passive ROM, gait training, and neuromuscular facilitation, so I decided to go back to school.

I did a 3-month fellowship with HealthSouth designed for PTs who wanted to become athletic trainers, then enrolled in school to complete the coursework required for athletic training. At the same time, I also earned a master’s in exercise and sport studies. I was certified as an athletic trainer by NATA in 1991.

A few years later I decided to sit for the American Physical Therapy Association sports specialty exam, and in March 1996 I completed the requirements and passed the exam to become an APTA sports certified specialist.

Primary Duties

My primary duty is patient care, performing evaluations and developing treatment plans for my patients. These are based on my evaluation, the protocols we have drawn up in conjunction with the physicians and other team members, and the patient’s own abilities and goals. The patient and I then implement these treatment plans. I work directly with my patients modifying the workouts, treatments, and home programs as necessary.

In many instances, athletic training and physical therapy licensing laws require PT supervision of ATCs, or they severely limit the ability of ATCs to practice in clinical settings (Cormier et al., 1993; Duncan & Wright, 1992; Farmelant, 1993; Morin, 1992; Olsen, 1996; Rello, 1996).

Our clinic and the Idaho practice acts of 1989 and 1993 allow ATCs and PTs to function in concert with each other. Both professions are allowed to evaluate and treat athletes. The PTs and ATCs in our clinic work together as a team, sharing expertise and ideas, and covering one another’s patients when necessary.

By functioning as a team with the exercise physiologists, through collegial rather than supervisory relationships, we have an effective, efficient, and broad-based sports rehabilitation facility. Our outcomes are good. We have low staff turnover and a stimulating, positive atmosphere in which to work.

The staff at ISMI have a great deal of freedom, within the framework of our protocols, to fine-tune each person’s program and to make adjustments as needed—speeding up, slowing down, emphasizing one area or another. No two patients are alike, and no two programs are alike either. I enjoy the contact with my patients and need their constant feedback in order to assess their progress and know whether the treatment is appropriate.

The real chance to be creative comes when working closely with an athlete, trying to find the best combination of work, rest, push, and pull to bring about the most rapid and effective recovery.

I see approximately 50 to 60% knee patients: ACL, MCL, patellofemoral, PCL, fracture, etc. Approximately 30 to 40% of my patients have shoulder problems: instabilities, tendinitis, rotator cuff problems, adhesive capsulitis. The remainder have hip, ankle, upper extremity, back, and neck problems.

Because of their areas of specialty and interest, the athletic trainers in the clinic who are not also PTs see primarily lower extremity injuries, although they may be involved somewhat with upper extremity and spine injuries.

In addition to patient care duties, I also coordinate clinical education for our facility by arranging and overseeing the internships of physical therapy students at our site. As is typical in the physical therapy profession (Gandy, 1995), we have affiliations with several universities and currently have at least one student most of the time. Because we are so specialized, most of our students are