You're listening to “Moving Ahead,” the physical therapy podcast by Washington University Program in Physical Therapy. In this episode, Dr. Greg Holtzman, Clinical Practice Director and Professor at Washington University's Program in Physical Therapy sits down to talk to Dr. Shirley Sahrmann, the renowned teacher, researcher, and clinician. Dr. Sahrmann shares her thoughts on the seminal events that helped to serve as the foundation for the APTA’s vision statement and provides advice for leaders and professionals to achieve success in a constantly changing healthcare system. She also reflects on the legacy and impact that Karen Donahue left on the profession.

Greg: Hello, my name is Dr. Gregory Holtzman and I am the Division Director of the Clinical Practice at Washington University Program in Physical Therapy. I'm happy to be joined today by Dr. Shirley Sahrmann, who will be joining us for this episode. And we're just really excited to hear from Dr. Sahrmann about her perspective about the profession of physical therapy, and just, you know, really excited that you're here with us today. So thank you for joining us.

Shirley: My pleasure. Thank you for asking me.

Greg: Great. So, one of the things I thought I’d get started with is talking about the American Physical Therapy Association and the vision statement that they put out several years ago, as you I'm sure know, the vision statement that was put out was, “transforming society by optimizing movement to improve the human experience.” I think this vision statement really allows the American Physical Therapy Association to at least put it out there that they're truly owning the term “movement.” And so, I was just trying to get a sense, from your perspective, regarding the history of the profession, how did we get here? And what do you think some of the seminal events were, that helped get us to the point where the American Physical Therapy Association was able to adopt that vision statement to include the term “movement?”

Shirley: Well, I think, from the 65-plus years that I've been in the profession, it's been pretty clear that everything physical therapists did was about movement. Our job was to get people moving again, their limbs moving and to get their bodies moving in functional ways, and arising from all kinds of problems that were mostly considered acute, acute problems. And the thing that the first time that the movement term was built into documents was back in about 1984. And then we basically had a philosophy statement that said, “Physical therapy is focused on movement-related activities.” And so since that time, there's been numerous documents that have sort of identified movement as playing a key role. And I also think it's very clear that all of our treatments are by about movement too. So we want it to produce movement, but in many ways, most of the concentration was on the components of movement; so making muscles stronger or stretching muscles, or in the case of neurological patient, trying to retrain the nervous system in spite of the disorder. And the APTA has had numerous campaigns to try to tie physical therapy to movement to try to say that that is our, our expertise. So that's… it sort of built up over time. And then was culminated in this new vision statement. But, but I think it's also a perspective on that vision statement to say that there was a statement made in 2000, called “Vision 2020.” And that vision statement was all about what physical therapists would be, like direct access practice, Doctors of Physical Therapy, diagnosticians, higher up in the professional scale, and I think that 2013 was a way of saying, “Okay, we're all these things now. We're going to turn it outward and say what we can do for society, because we've escalated the profession in these in these various ways.”

Greg: Yeah, I think that's a really interesting perspective, as far as kind of, you know, starting more internally, trying to define what the profession looks like, and then moving more toward this outward look for the profession and how we can impact society and so on and so forth. Having been a part of the House of Delegates when that vision statement was adopted, it was really exciting to be a part of that and to think about how the profession is going to look and for years to come. So I'm curious just kind of based on that, what would be your advice to current physical therapists or students as they look to adopt the vision statement, and more importantly, embrace movement as a core tenet of the profession?

Shirley: Well it… I think there's going to be a lot, a lot of work on on the part of new therapists as they join the profession. Number one is, even though we've been associated with, with movement, I think to me one of the key parts of the vision statement, which I don't mind telling you, I thought somebody was smoking something when I first read it is like, you know, we can barely keep ourselves together, now we're going to enhance all of society. And this was the guidelines that went with that statement. Because the first guideline was that the movement system will be our, our identity. And since 1975, the profession has had a problem with its identity. That was pointed out by Helen Hislop and Herb McMillan, and it's been a constant tenant of the profession. And I think that is still a problem. As I mentioned just a minute ago, the movement is so big. And we have looked at the components of movement, but we've never put it together as a movement system. And the reason why I think that's so important is because then it gives us recognition for a body system, instead of just people out there to make people move better. And one of the prevailing lines that's prevalent in the profession is, people know what we do, but they don't know what we know. And they value us for what we do, instead of what we know. And we've never made it clear. We're going to help movement, but how? So we're doctors, but are we really looked at as doctors? And I think this is where expertise in a body system becomes so important, and why it has to be promoted that way. And that what physical therapy can do is put all of those components together, sort of the the bio-control, the biomechanics, the bioenergetics, into a system of the body, and then have diagnostic categories related to that system. So the vision statement was one thing, but the guidelines in really adopting the movement system, and I think what it did was take us out of the silos, looking at muscles separately, nervous system separately, cardiopulmonary separately, and say, “This is the whole system for which we're responsible.” So, and one of the things… there are two important things that I think the profession has to do to fulfill this desire, and that's what is going to be the responsibility of the young people coming on. It's number one, to recognize the conditions are no longer acute conditions. What we're dealing with today, are chronic conditions that start early in life and continue on. And they're lifestyle related. That's why we can transform society, because how you move is… has a lot to do with the kind of problems you're going to get in your musculoskeletal system. And if you don't move, you're going to get them in your metabolic system. So how you move, what you do, how it fits with your structural characteristics. So they’re chronic, they’re lifestyle. The other big thing that has to change in the profession, is a true emphasis on understanding the movement system. instead of gaining all of our recognition for what system of treatment we use. People still get their recognition for being a manual therapist or an NDT therapist or an MDT therapist, and not for their knowledge of the movement system. And I understand there's even a downplaying of the Kinesiology in many educational programs. So, the time in which we should be highlighting our knowledge of all of the systems, we're not doing that. And I think the other thing that people have to deal with is this big push for productivity, because they're making less money. So they have less time to do a really good job and think about what they're doing. So there's a push to just hurry up and get it done. So I think you have to put all these things together. Recognize that we're dealing with chronic problems, recognize that you got to understand the condition, how it's related to movement, instead of “I'm the world's best manual therapist,” or, “I know how to do press ups.” I think these are really important, really cultural changes for the profession.

Greg: Yeah Shirley, I definitely have to agree with you in terms of, you know, thinking about some of the challenges that we face as a profession moving forward. And I really like kind of what you're saying about this recent, and not even recent, but we've always been focused on some more of the intervention part of it and really kind of figuring out what we know is going to be, I think, critical. And then you spoke about this idea of, you know, again, kind of addressing movement and really thinking about how movement is so critical in our lives, even from a very young age. I know you've often talked about this idea of physical therapy as a profession adopting more of a dental model of care. And you know, from a dental perspective, you know, we are conditioned from a very young age that we're supposed to be going to the dentist every six months for prevention and care. And it really becomes more of a strategy of trying to, you know, make sure things don't happen, you know, negatively to our teeth, or anything of that nature. And it's been a really successful model from the dentist perspective. Given what you've talked about the importance of movement, can you kind of express why a dental model for physical therapy might be a really positive thing for us to try to pursue?

Shirley: Well, I'm so glad you asked that, Greg, because one of the things and again, this goes to this emphasis on understanding the condition. And if you have a profession that's just focused on treatment methods, then you have to have a condition to treat it, you can't do prevention. And one of the things also that has not happened is the recognition of how movement can be improved. I mean, I, I typically like to ask patients, like, “Who taught you to walk?” and when they say, “Nobody.” I say, “That's the problem.” It's not just because it's not just that you do something, but how you do it. And there are ways to do it better. Plus, the other thing is structural variation. So just like people come with teeth that aren't shaped right, and they put braces on them. And I think there's great irony, because I always say you only speak and eat with your teeth, and you need your body for everything. And yet, there's nobody out there taking charge of it, nevertheless, looking at it twice a year or even once a year. So number one, our selling has to go into saying how much movement can be improved. That just because you're doing it doesn't mean you're doing it right. And, and that's a big challenge. People think that as long as it doesn't hurt, it's all right. Well, that's not true. The other thing that we need to do is identify structural variations, just like, as I say, the teeth come in different ways. My cousin made a great living putting braces on people's teeth. So they've made it important. And we should make it important because it is important. I really believe that if physical therapists do their job right, we're going to be able to say we're the ones that can slow down the onset of osteoarthritis. And believe me, at my age, you'd rather get it at 80 than at 50. And that's what I think we could do in the prevention thing, just like dentists to help to keep teeth from from falling out. The other reason, and but people again, have to understand the condition to do prevention. And we can't be focused on treatment methods, we've got to be able to do an exam that says you're measuring up or you're not measuring up. And we could really do that because we're not only the ones that can say, you can exercise, but we're the ones that say if you exercise this way, or if you select the right activity, you will enhance your body. I mean girls that have femurs that turn in and don't turn out cannot do ballet as a profession. They need to know that early on before they establish their identity with a sport that is not good for them. And they need to be active. So there's lots of things that we could do that would make movement better. I love going on the internet, just looking at pictures of kids in exercise groups. I want to call 911 right away because of the kind of body configurations they're in. And I wish I were kidding, but I'm not. It's really appalling. And then some people think certain activities are really good for them, but they push them to extremes where they shouldn't go. So I think it's critically important. The other reason that I like the dental model is that the dentists stand on their own. In other words, if you think about, “What's the most money I could spend going to a dentist?” it pales by comparison. What… what happens when you start down the physician ranks? The cost, and we're just a little widget in that great big cost, which is why we're going to keep getting squeezed out. So the more we're seeing as our own purveyor, excellence in a body system that we can do something for prevention, not just helping reduce symptoms, and if physical therapists knew we could treat cause, not just symptoms. That would be a huge step. If we can orient people to the importance of modifying their movement, like the dentists have made importance out of keeping your teeth optimal. All of it, just like exercise reduces inflammation, keeping your mouth clean, reduces inflammation. What's the biggest worry about everybody has these days? Inflammation is a cause of all kinds of medical problems, health problems. So that's why I favor it. I am hoping that we will be lifespan practitioners. We need to be seeing people yearly. We don't need… how can we be following this acute model where you get six visits, never to be seen again? That it makes no sense. These are treated in six visits, and then the condition goes away. It's there all your life. So the whole perception of what the role of the physical therapist needs change, and the move to the movement system, responsibility for a body system, having doctors, now I just want those doctors to be seen as doctors. Because we also need to have diagnostic categories. One of the other veins of our existence is high variability in practice. And as long as there's variability in practice, we're not going to be able to show value, because to the same condition is treated in five or six different ways. Not based on knowledge, but based on what is the technique I know. So the dental model for prevention, dental model for standing alone, dental model for saying, this body system is really important, it's probably even more important than your teeth, or your oral cavity. So that's why I like to make that analogy.

Greg: Yeah Shirley, those are so many of those points are really, really great. And I certainly have always appreciated this idea of that you brought up the dancer, and the dancer that's required to do a certain level of turnout in ballet, but doesn't have the hip structure to be able to do that. I mean, to be able to catch that early on, and redirect that individual could be such a valuable tool to prevent a lot of type of injury and problems in the future. And so I just think this type of model is, is certainly something that we should be moving forward with. I'm curious because, you know, it's, it's actually, I'd like to test and get your perspective on this. It's come out a couple of times when I've been at different continuing education conferences or something like that related to running. As you know, I'm really invested in the running community, as well as evaluating, treating runners that come in with specific injuries. And there's this, there's been this debate in kind of recent months, years about changing running mechanics. You know, one of the complicating factors is we really don't know if there's a specific ideal, but we have an idea of what's better than not. But one of the things that has kind of come up and as a debate is, if you're seeing a runner, for example, that doesn't have any pain, but you notice that their mechanics really aren't ideal, should you change them? Or should you just let that run or keep running and not modify those stresses? Now, I know where I sit on this argument, but I'd like to kind of get your perspective on that.

Shirley: I have heard that too. Like, if it doesn't hurt, then why fix it? And then I say, “Well, I don't think many doctors are waiting until you have your stroke, when your blood pressure is high.” Not many doctors say, “Go ahead and let your blood sugar get high, and then when you get your diabetes come and see me,” or, “Don't let your cholesterol… Let's have a heart attack first and then I know your cholesterol was problematic.” There are signs before there are symptoms, and the cost… and, you know, I'm in the midst of medical issues myself, and what the cost, the prevention that goes on now with medicine is more than what they're labeling… more than what it's labeled. It mean, the difference between how my parents were treated, versus how I'm treated with similar conditions is night and day. And so, in fact, one of our problems is people are living too long. I mean, my parents’ generation, people were gone in their 60s. That's why you could have a 30 and out policy for the car manufacturers. I'm serious. Now we live until 80. And why? Because people are taking care of preventive things. The same thing is true, Greg, as you know, so well. There are signs before there are symptoms. I don't want to wait until it gets too expensive. That that is the whole crux of medicine. And again, that's another reason why physical therapists have to do their job, right? Because we're not showing how important movement is. We're not showing that there's a right and wrong movement. I mean, just like I've always enjoyed the fact that, where do you find the most musculoskeletal problems? With athletes. Not because everybody's playing football and getting hit, it’s because of what happens as they do an intense activity. And the people that are the best built are the ones that last the longest. Because they are. And you can make it better by modifying what other people do. So how bad… and I'm sure if you saw somebody that had Jaime Valdez of a big time. You don't say I think running marathons is a really good idea for you. I mean, so it's matching it up, and it's doing preventive things. The mechanics are bad, so don't use them. That's what it's about.

Greg: Yeah, I really appreciate that perspective. And, you know, thinking about this, I even on the internet the other day I was looking at, you know, through various things as it relates to training for football. And they showed this picture of a team and they had five individuals that were going through a squat position. And there is one individual that, you know, was clearly kind of collapsing in their hips and knees. And you could, you know, it was just… I sent it to one of my colleagues, like, which one of these individuals is going to get hurt in the near future? And, you know, it's just so easy for us to identify these problems. And we can have such a big impact on identifying them and fixing them before they become significant issues. So…

Shirley: Yeah, I did the same thing with… I talk to the students. I mean, I went on the internet. Here's a guy in a competitive run and his right leg is turned out so laterally, that he's practically running on his medial malleolus. Now, how long is he going to be running?

Greg: Right.

Shirley: Wait until until it really fractures? And then we'll say, I wonder what happened?

Greg: Exactly, exactly. No, I definitely appreciate that perspective.

Shirley: When you know, you know?

Greg: Exactly. Well, thank you for that perspective, I think it's just really good to be able to hear that and kind of understand from a movement perspective, what we're really good at, or what we could be really good at, and to really help kind of lead to this prevention model. As we move forward with the profession.

Shirley: I want to make one other important point, because Washington University is such a strong site for really great research. And, and again, you know, I've been in this profession for so long, and I watched it from when there was barely any research at all, to amazing amounts of research. But I've asked a number of people, and research is not being incorporated into practice. And why not? Because people aren't ready to consider the condition. Again, it's about this emphasis on treatment and not understanding what's going on. So we're losing out on a lot of good work, by doing that. We're losing out on the on the recognition, by not pushing along, and saying, putting the emphasis on what we know, and on diagnostic categories of that system that we know. And one other thing that I get accused of is like, instilling “kinesio-phobia” if we worry about how to teach people how to move. While we're teaching people how to move, so it doesn't hurt. And that's the best way to not have “kinesio-phobia.” It’s that, “I don't know what I'm doing that causes me to hurt.” That's a problem. So I think there's every reason to push on with this identity of the movement system. And to do what Washington U is working at so hard, is to develop diagnostic categories that direct our treatment.

Greg: And I agree with that, Shirley, and just to sort of comment on this idea of “kinesio-phobia,” I can't tell you how many times, I'm sure you've done the same, I've worked with patients and described, from my perspective, what they might be doing wrong with regards to their movement, or maybe is not optimal, or things that can improve upon. And the overwhelming sentiment is appreciation, and you know, about learning kind of what they're doing, what they can do better, and trying to understand how to prevent, you know, symptoms from occurring, and you know, in the future. So I think that's a really excellent point.

Shirley: Well, and Linda Van Dillen’s publication in the Journal of the American Medical Association, clearly shows that changing the way people do their everyday activities, is the fastest and most effective method of dealing with chronic low back pain. I mean, and you don't just get published in JAMA. So it's a landmark article.

Greg: Right.

Shirley: Which is real… and then it also, Greg, it supports what we're talking about. It says the way you're doing your everyday activities that causes the problem in the first place. So you got to fix it.

Greg: Exactly.

Shirley: But what we're trying to say is let’s fix it before you've got a problem. Wouldn't that be spectacular?

Greg: Novel, right? Exactly. Shifting gears just a little bit, just to kind of bring us into our current times, relative to the pandemic. I'm just trying to get your perspective from a historical perspective relative to kind of where the profession of physical therapy, you know, was sort of rooted or grounded, maybe in the polio epidemic. How does that compare to what we're currently going through with COVID? And how might that shape our profession for years to come?

Shirley: Well, I'm happy to, well, maybe happy and unhappy to say that the polio epidemic was never like this. You certainly worried in fact, to this day, I'm still reticent about swimming because it was known that you would get from swimming, in droplets. But, you know, in thinking about this, people weren't as up close and personal, in days of old as they are now. If you went out to dinner, for example, it was like a really big occasion. You weren't out amongst people all the time. And you were outside and indoors because there really wasn't even a lot of air conditioning. And the other thing was, there wasn't TV. TV was just coming in, in the, in the 50s. And, and the polio vaccine came out in about 1955. So, and I didn't know anybody that had polio. You knew about it, and that's why I wanted to go into physical therapy because of polio, I wanted to help those little paralyzed kids, and it was mostly children. There was no work stoppage or, or any of the rest of it. But what polio did, and happily… I’m kind of smiling for the paradox, but Franklin D. Roosevelt, who was the president, had polio. And so he put all of his emphasis in might behind polio. And actually, that was the big development of interest for our physical therapy. Before, physical therapists were out there, but nobody thought they could do anything with stroke patients, and we weren't saving the lives of spinal cord injured or head injured people. So the emphasis by Franklin Delano Roosevelt putting money, a lot of people got to go to school because of the scholarships for polio, the recognition that somebody could help people that were paralyzed, really opened the door for physical therapists to start treating other kinds of patients. And then they were just beginning to save the lives of the spinal cord injured and head injured in the 1960s. Of course, that presented a real complication, because we had treated the lower motor problems where the nerves, the muscles went away, because the nerves were gone at the spinal cord level. And they were replaced by the upper motor neuron syndrome. And nobody knew how to treat those. In fact, that's sort of what started this emphasis on treatment methods, because nobody could understand the underlying conditions. So they just said, “Okay, well Bobath knows how to treat those people. So we'll do Bobath.” Or maybe not, it actually wasn't, maybe not, it was, I can't think of his name right now, it was actually not even a physical therapist that developed TNF. And they, so they started in on treatment methods that we've never undone. So polio had a big impact. It got us going. Money got behind physical therapists. We got recognition. But then the problem switched. And we switched that we need to switch back to understanding the condition that we did with polio. It was a very different world then. But I'm happy to say it did not have all of the repercussions at that time that this pandemic has had in this era.

Greg: Yeah, and I appreciate that perspective, in terms of like looking at it from a historical perspective. It will be… it remains obviously to be seen how the current COVID pandemic could shape the profession of physical therapy moving forward. Clearly, we're now seeing individuals in our clinics. So they're coming to us with all sorts of issues related to you know, deconditioning, fatigue, muscle strength, things of that nature. So, it'll be interesting to see how it shapes not only healthcare, but the profession of physical therapy moving forward. But I think we've got some perspective.

Shirley: Well, you know, I think one of the things we have, I mean, good news, because yes, they need people to get reconditioned and go back again. And, a little bit of what what I worry about with this, number one is, you know, they're trying to reduce the reimbursement for physical therapy. And are they just going to encourage people to go to any kind of exercise person? Because in some ways, we have not established our expertise in exercise. I mean, if you ask somebody, they want an exercise program, they're going to say, personal trainer, pilates teacher, yoga teacher, and not a physical therapist. And I think the push for low cost, and more generalized programs is going to… and this would be an opportunity if physical therapists would jump in and have big gyms. And then they would make sure they get trained in a way that really takes care of all of their problems and not just pushing activity for activity’s sake. We could escalate and, and I think people ought to be thinking about paying out of pocket for me. But again, you would have to be recognized that you know something, that you're worth paying out of pocket, almost as much as a personal trainer or a pilates teacher.

Greg: Right, exactly. Exactly.

Shirley: A little bit of sarcasm there. But anyway, I think that's the big… there's probably opportunity, but I don't think in the way it's been the past 100 years, I think we have to look at a different business model as well as different practice model.

Greg: Great. Well, I certainly appreciate that perspective. And I know we're getting time here trying to wrap up and I wanted to spend a little bit of time to focus on a member of our American Physical Therapy, and specifically, our Washington University Physical Therapy community that we recently lost. Karen Donahue, a physical therapist and a graduate of our Washington University Program Physical Therapy. She was based out in an area Arizona, Phoenix, Arizona specifically, and her untimely passing in the past couple of weeks was certainly a shock to all of us. And I wanted to give an opportunity to be able to comment on her and what she meant to you, as a student, as a person, what she meant to our profession, and what she meant to some of our students coming in from the Program of Physical Therapy and the physical therapy community at large.

Shirley: Yeah, Greg, I'm so happy to be able to comment about Karen. She was truly a unique person. In fact, we have to be forever grateful to Karen because it was her role. She's the one that got the movement system identity into the vision statement, and got us started moving down that pathway. And Karen was the ultimate, kind of get it done, help people, move things along in a in a better, better way. She was a great mentor. She tried to follow all of the things that she learned at Washington University. She was very committed to the professional association. She was in the House of Delegates. Always, always pushing ideas amongst people, being a mentor, not only in clinical practice, but also in professional activities. She would go out of her way to help anybody, do anything for them. We would have retreats every year, and for years, she did all the cooking. I mean, so it was even down to providing the food, the resources for the body, and the food for the brain and, and always joyous, outgoing. I don't think I ever saw in a bad, down state. She was arranging to push the movement system. We were to do a program together in October, and, you know, to help push things along. So it's a devastating loss to all of us because she was such a leader. And she started her own private practice after graduating from schools, and had no trouble pulling it off. And it was always about quality. It was always about helping people to become better clinicians, better participants in their professional activities. So I can't say enough good things. And it's a terrible loss and shocking to, to all of us. I don't know, there probably aren't words adequate enough to explain all of her contributions, but they're there and they'll go on for years.

Greg: Yeah.

Shirley: She will not be forgotten.

Greg: I so much agree. She was such a strong influence on many of our students. I remember personally meeting her for the first time at one of our retreats and really speaking with her and getting to know her and, and ever since that point, she always embraced me, as you know, as this, you know, as a person, as a physical therapist, speaking with her at additional retreats or conferences or when she would come to St. Louis to visit, or even a time that I went out to Arizona and visited some clinical education sites and was able to stay with her and really have some time to spend with her there. Just a wonderful individual. And for sure, she will most certainly be missed. And so I thank you for, you know, being able to speak to her influence within the profession, with you personally, and with all of us that work at Washington University Physical Therapy.

Shirley: Well, and that's why we got a scholarship in her name because her name cannot be forgotten. It's got to be tied with us forever.

Greg: Exactly. Agreed. So, well thank you, Shirley. I really appreciate you joining us today. For this podcast. It's been a wonderful conversation. I've really enjoyed chatting with you. And you know, it's always great to hear your perspective and I really appreciate it. So thank you very much.

Shirley: My pleasure. Thank you for asking me.

This has been “Moving Ahead,” the physical therapy podcast by Washington University Program in Physical Therapy.