



**The IFSHT is excited to present edition six of the quarterly newsletter, REACH.**

This publication aims to collate Research, Education, Achievement and Clinicians in Hand and upper limb therapy around the world.



**Peggy Boineau**  
*IFSHT President (2022-2025), USA*



It is my privilege to introduce the final edition of Volume 2 of REACH. As we near the end of 2022, our Publications Committee Chair, Daniel Harte, and his esteemed international committee have created another edition of this informative, professional newsletter that is packed with useful articles for hand therapists around the world.

What a year this has been! Our lives are forever changed as we embrace the positive developments and bear the tremendous loss caused by the pandemic. On a positive note, REACH was born at the Executive Committee's in-person meeting in London, February 2020, at the dawn of the pandemic. Despite global chaos, the Publications Committee has successfully delivered 6 excellent editions of REACH. Digital technology accelerates the ability of hand therapists to collaborate and learn from one another on a global basis. For example, the 2022 IFSSH, IFSHT, and FESSH Combined Congress in London, was a wonderful event during which we celebrated the opportunity to attend in-person and embraced the chance to engage with presenters and attendees participating in the Congress remotely. At our previous Congress, a virtual component was just an interesting discussion. Suddenly virtual education is a positive part of our new normal. Through our digital newsletter, our website and social media platforms, IFSHT plans to keep moving forward to seize the opportunities afforded us by the digital age.

While IFSHT is celebrating the successes of 2022, we are on our way to a very productive 2023-2025 term. Allow me to take this opportunity to introduce you to our new Executive Committee: President-Elect, Stacey Doyon (USA), Secretary General, Marie Eason Klatt (Canada), Treasurer, Elizabeth Ward (Australia), Information Officer, Susan de Klerk (South Africa), Past President, Nicola Goldsmith (United Kingdom), and myself as President. The new Executive Committee has been working hard via our virtual office, email, phone calls and virtual meetings to carry out our goals for this triennial period.

As another year comes to an end for us on this rotating ball that we call home, I hope you have enjoyed a successful year. As for IFSHT, we remain a strong and growing organization. We currently have 56 members representing 11,258 therapists worldwide. Our future is bright as we harness the power of this digital age to accelerate our efforts to promote networking and education for hand therapists on a global basis.

I am sure you will enjoy this publication of REACH. Please read, digest, implement and share the knowledge contained here.

I wish you a very happy and successful 2023 and I invite you to join us in Washington, D.C., 24-28 March 2025 for the next IFSSH / IFSHT Triennial Congress.

**Peggy Boineau**  
*IFSHT President (2022-2025)*  
**USA**

# New and Noteworthy

Written by Mia Erickson, PT, CHT, EdD. *Midwestern University, Glendale, AZ*

Ahmadi AR, Duraku LS, van der Oest MJW, Hundepool CA, Selles RW, Zuidam JM. The never-ending battle between proximal row carpectomy and four corner arthrodesis: a systematic review and meta-analysis for the final verdict. *Journal of Plastic, Reconstructive & Aesthetic Surgery*. 2022;75:711–721. <https://doi.org/10.1016/j.bjps.2021.09.076>.

The purpose of this article was to provide individuals with an updated systematic review and meta-analysis of studies comparing outcomes from two wrist surgeries, proximal row carpectomy (PRC) and four corner arthrodesis (FCA). These surgeries are common in the surgical management of SLAC (scapholunate advanced collapse) and SNAC (scaphoid non-union advanced collapse) degenerative arthritis. Information from this paper can be useful to therapists in that it can help in understanding expectations for the two procedures.

Authors included studies that looked at outcomes from PRC and/or FCA that were used to treat individuals with wrists demonstrating SLAC or SNAC. Outcomes of interest included range of motion (ROM), grip strength, complications that resulted in reoperation, the need for total wrist arthroplasty, visual analog scale (VAS) for pain, and results of the DASH questionnaire.

The National Institutes of Health study quality assessment tool was used to carry out the risk of bias assessment (<https://www.nhlbi.nih.gov/health-topics/study-quality-assessment-tools>).

After screening over 1600 studies, authors were able to identify 15 papers that met their inclusion criteria. Data from 322 people following FCA and 328 people following PRC were analyzed. The length of the follow-up time ranged from 6 months to 18 years. The mean follow-up time was ~ 5 years. The mean age of the individuals in the FCA group was 48 and the mean age of the individuals in the PRC group was 46. Many studies had serious risk of bias including the lack of sample size justification and blinding. According to the meta-analysis, authors reported to significant differences between ROM, grip strength, number of complications, number of conversions to total wrist arthroplasty, VAS pain scores, or DASH scores between the two procedures.

In addition to the information provided from the results of the study, the paper itself is informative in explaining SNAC and SLAC degenerative arthritis and both surgical procedures. Excellent images are also provided. The tables are easy to understand and provide excellent summaries of the studies that were included.



## Other New and Noteworthy from 2022

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## RESEARCH DATA AND INTERPRETATION: Measurement Properties of Patient-Reported Outcome Measures

Written by Dr Cynthia Srikesavan, Senior Researcher in Physiotherapy, Rehabilitation Research in Oxford, Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences, University of Oxford, UK

This is Part Three of a tri-series on the basics of understanding research data in journal articles. So far, we looked into different types of data, and various ways of summarising (descriptive statistics) and analysing those (inferential statistics). This final section will focus on the measurement properties of patient-reported outcome measures (PROMs) that help us make conclusions about their adequacy for use in clinical practice and research.

Patient-reported outcome is “any report of the status of a patient’s health condition that comes directly from the patient without interpretation of

the patient’s response by a clinician or anyone else” (FDA 2009).<sup>1</sup> Patient-reported outcome measures (PROM), mostly in the form of self-reported questionnaires, evaluate a wide variety of constructs such as symptoms, function, and quality of life; and aid in planning/evaluating the benefits and harms of interventions and help improve patient-health professional communication. The quality and usefulness of a PROM depends on its measurement (or psychometric/clinimetric) properties such as how reliable and valid it is and how effectively it can detect changes of clinical status after an intervention.

The **CO**nsensus-based **S**tandards for the selection of health **M**easurement **I**Nstruments (COSMIN) initiative developed a taxonomy of measurement properties within three major domains: Reliability, Validity and Responsiveness<sup>2</sup>, discussed below. We will also briefly describe the floor and ceiling effects.

## Reliability

Reliability is of two types: Test-retest reliability and internal consistency.

Test-retest reliability evaluates whether the results remain consistent for repeated measurements. The test-retest method repeats the questionnaire under similar testing conditions, with the same respondents who remained 'stable' in their clinical status at the time when the second session was conducted. A short period of time usually 1-2 week interval, is allowed between the measurements, sufficient enough to avoid recall bias. More the results of both sessions are consistent; we can conclude the measurements were stable and highly reliable. Test-retest reliability is measured by the correlation between first and second session scores by Intraclass correlation coefficient (ICC) for continuous data or Weighted Kappa for ordinal scores. The ICC is reported as a value between 0 and 1. Interpretation of ICC is: values above 0.9 indicate excellent reliability; between 0.75 and 0.9 good reliability; between 0.5 and 0.75 moderate reliability and values below 0.5 represent poor reliability.

Measurement errors are likely to happen with any retesting and they are calculated as standard error of measurement (SEM) that tells us how repeated measures on the same outcome measure are distributed around unknown true score. SEM is directly related to the reliability statistic and calculated as,  $SEM = \text{Standard deviation of the sample} \times \text{square root of } 1 - ICC$ . This means, if ICC is higher, the error will be smaller and vice versa.<sup>3,4</sup>

Internal consistency refers to how far the items of a PROM are inter-related to each other. Internal consistency is measured by Cronbach Alpha, which gives a coefficient of reliability between the items. Cronbach Alpha is provided as a value between 0 and 1, with the acceptable range between 0.7 and 0.95. The maximum value recommended is 0.90.<sup>5</sup>

A low Alpha indicates poor-relatedness of the items, while a very high Alpha may indicate redundancy of some items.

## Types of validity

The following are the most common types of validity you would come across in articles reporting the psychometric properties of an outcome measure. Structural validity and cross-cultural validity are not covered in this section.

### Content and face validity

Content validity of an outcome measure is about making judgements about the relevance and comprehensiveness of items, usually by a group of experts including patients and health professionals. Face validity is a subjective judgement to determine how far the items of an outcome measure reflect the construct it was supposed to be measured.

### Construct validity

This refers to the degree with which the scores of an outcome measure relate with other comparator measures in accordance with the hypothesis defined by the research team (whether they converge or diverge). Construct validity is determined by the strength and direction of relationship between the variables, and reported as correlation coefficients ranging from -1 to +1. Pearson correlation coefficient ( $r$ ) is used when variables are normally distributed, and Spearman correlation coefficient ( $\rho$ ) when they are non-normally distributed. There are several approaches to interpret the strength of the coefficients, with values closer to -1 or +1 indicating 'very strong' correlation and values below 0.1, a negligible correlation. A correlation coefficient of 0.65 is considered 'moderate' or 'good'.<sup>6</sup>

## Responsiveness

Responsiveness is another aspect of construct validity (or longitudinal validity) that determines how an outcome measure can detect changes in health status over time. Traditionally, responsiveness is measured by effect size (ES), standardised response mean (SRM), and minimal clinically important difference (MCID). Effect size is calculated as 'Cohen d' which is the difference between the mean of measurements 1 and 2 (before and after

treatment) divided by standard deviation of the first measurement. SRM is calculated by dividing the mean change by the standard deviation of the change score. Cohen's d and SRM values of 0.2, 0.5 and 0.8 are usually interpreted as small, moderate and large responsiveness.

MCID is a patient-centred concept that tells us the smallest amount of improvement after an intervention that is considered meaningful for patients. It is either statistically evaluated or through anchor methods where an external anchor tool (example: global rating of recovery or satisfaction with treatment) is used to measure change in an outcome over a period of time.<sup>7</sup> For example, MCIDs of the Michigan Hand Outcomes questionnaire (0 to

100, 100 indicating best score) evaluated in people with carpal tunnel syndrome nine months after surgery and those satisfied with treatment were 23, 13 and 9 points for pain, function and work domains of the questionnaire.<sup>8</sup>

## Floor and ceiling effects

Floor effect means when most of the patients found the questionnaire items too difficult and therefore score within the lowest range. Ceiling effect means when most of the patients find the items very easy and their scores fall within the highest range of score. Floor or ceiling effect is defined when 15% or more of the study sample score the lowest or the highest level of scores.<sup>9</sup>

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## More resources

1. Tips to select an outcome measure for your clinical practice or research: [https://www.physio-pedia.com/Guide\\_to\\_Selecting\\_Outcome\\_Measures](https://www.physio-pedia.com/Guide_to_Selecting_Outcome_Measures)
2. Database to identify systematic reviews on outcome measures: <https://database.cosmin.nl/>
3. Database to identify various outcome measures used in rehabilitation: <https://www.sralab.org/rehabilitation-measures>



# Rehabilitation of Triangular Fibrocartilage Complex (TFCC) Injuries

Luke McCarron MSc (Hand) BOcc Therapy, Accredited Hand Therapist, CHT, Orthopaedic Conjoint Bond University Australia followed up his review of TFCC assessment with an overview of rehabilitation of this injury.

Key areas of intervention consists of pain management (including orthoses), proprioceptive exercises, functional taping, guidance on activities of daily living and strengthening work. This review delves into management strategies for acute-stable and acute-unstable TFCC injuries and when surgery may be required. Provocative tests to help determine stability of the distal radioulnar joint are also discussed. Luke reports that chronic injuries (defined as 6-months or longer) and in his experience such chronic-stable injuries are common in athletes and industry workers, while chronic-unstable injuries are more common in an elderly population.



[Click here for the full article](#)



# Research in Action – Levels of Evidence

Written by Mia Erickson, PT, CHT, EdD, [Midwestern University, Glendale, AZ, USA](#)

## Level 5 Evidence

Welcome back to the Research in Action column. This is our last segment on Evidence-Based Practice providing overviews of the different levels. This issue will present an overview of Level 5 evidence.

According to the Centre for Evidence Based Medicine,<sup>1</sup> Level 5 evidence includes “expert opinion without explicit critical appraisal, or based on physiology, bench research or first principles.” While it is often considered the lowest level of evidence, it

is important to note that a practitioner integrating principles of evidence-based rehabilitation may need to use level V evidence in the absence of any higher-level evidence available. This may be the case when the topic is considered to be novel, when a condition is rare, or when no high-quality, empirical studies are available. For example, in 2014, a paper by Herman and Raybould<sup>2</sup> stated that, “expert opinion is often sought by government regulatory agencies when there is insufficient



empirical evidence to judge the safety implications of a course of action.”<sup>p8</sup>

In the clinical practice guidelines available through the Academy of Orthopedic Physical Therapy of the American Physical Therapy Association (Available at: <https://www.orthopt.org/content/practice/clinical-practice-guidelines/published-cpgs>), authors are able to provide Expert Opinion recommendations. These recommendations are defined as “Best practice based on the clinical experience of the guidelines development team.”<sup>3,pA,4</sup> In the clinical practice guideline on adhesive capsulitis, authors provided this level of recommendation for clinicians to recognize that people with adhesive capsulitis present with gradual and progressive pain and loss of active and passive motion in elevation and rotation.<sup>3</sup>

Ways to gather the opinion of many experts is to convene a consensus panel or to perform a study using a design called the Delphi process. In a recent paper, the authors defined a consensus-based process as one that guideline panels use when the evidence is low quality or very low quality.<sup>4</sup> In another paper, authors indicated that consensus panels can be convened when evidence is limited.<sup>5</sup> In this latter scenario, the consensus paper that summarizes the opinions of the experts is more focused than an entire clinical practice guideline. One limitation of these panels is that the methods

for development may not be specifically described in the paper, and the process for developing the methods often differ by professional societies.<sup>5</sup> The Delphi process is a research design, usually administered via multiple rounds of surveys where experts reach consensus on important aspects of the topic. In a recent study published in the Journal of Orthopedic and Sports Physical Therapy, authors used a modified Delphi technique combined with an international consensus panel, in-person meeting to develop recommendations for shoulder injury prevention, rehabilitation, and return to sport for athletes at all levels. The justification for this approach was that there was a lack of quality evidence on this topic.<sup>6</sup>

Expert consensus statements that are developed based on high levels of evidence such as systematic reviews and meta-analyses with results all pointing in the same direction are not considered Level V. Those are considered pre-appraised literature and are generally considered very high level. In addition, in areas where high-level evidence becomes available, expert opinion consensus documents should be revisited and may require revision. In the absence of high-quality evidence, expert opinion can be valuable for clinicians. It is important however that clinicians realize that expert opinion may be replaced at a later date as higher-level evidence becomes available.

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# Clinical Pearls

In this section we feature clinical pearls which should be applicable to most hand therapy settings. **We welcome your ideas.** Submit them to [informationofficer@ifsht.org](mailto:informationofficer@ifsht.org).

## Extension Tendon Zone 1

Submitted by **Andrea Moser, OT Certified Hand Therapist (ÖGHT), Austria**

### Duration of splint regimen

After a mallet injury it takes about 10 to 14 days for a very delicate scar tissue to develop. I check the resilience of the tendon scar by performing what I call the "hover test". If the fingertip can be kept in active extension without any further lag then a splint regime can be established. If the "hover" test is positive then I recommend that bony mallets are in splint for six weeks and soft tissue mallets for 8 weeks. If the hover the test is negative they will need longer.

### Splint management

No matter which model of splint is made, it has to fit exactly (see Figure 1). Therefore custom-made splints by hand therapists are best to achieve this.

Caution is necessary when removing the splint for skin care because the DIP can fall into flexion, widening the tendon scar. To avoid this changing the splint by the client is only recommended after a positive "hover" test. Until then, the splint may only be removed together with the hand therapist.

Figure 2 illustrates an education technique for clients who have sustained a mallet injury.

### Out of splint

Whenever the continual splint regime comes to an end, night splinting usually continues for several more weeks and gradual return to function and ROM is commenced. For individuals with manual jobs, a "cross splint" can be made which limits DIP flexion and at the same time supports extension. This is made using an Orficast strip cut to a width of 5mm and wrapped in a "figure of 8" (Figure 3). Because the splint material is cut very narrow, it allows for both, protection and mobility.



Figure 1: Different types of splints used for mallet injuries



Figure 2: A visual method to educate clients on tendon healing



Figure 3: the "cross-splint"



# Lifetime Achievement Awards

IFSHT celebrated the careers of a number of Hand Therapists at the 2022 IFSHT congress. Each of them was presented with the prestigious IFSHT Lifetime Achievement Award for Contribution to Hand Therapy. In the REACH newsletter we profile those therapists who, as you will see, have trail blazed and left an enduring mark on the specialism.

Compiled by Toni Rippey

## Jennifer (Jenny) Ball

Jenny is a physiotherapist who resides in Tasmania, Australia. She began her physiotherapy journey in 1981 and now has over 38 years' experience in the fields of Hand, Upper Limb, Plastics and Burns Physiotherapy. Her professional goal currently is to prevent disability from trauma, congenital conditions and diseases of the hand, and from whole of body burns, through expert clinical practice, research, teaching and mentoring, both in my own community and in the developing Asia Pacific region. Jenny is a certified hand therapist (CHT) since 2004 and an Accredited Hand Therapist as awarded in Australia by the Australian Hand Therapy Association since 2017. She founded her own private hand Therapy practice in 1993 and continues to work at the Royal Hobart Hospital as a senior clinician since 1983.

Jenny has extensive experience in her participation and development of outreach and volunteer programmes. Jenny has written and presented a 5 day 'Hand Trauma and Burns Management' course curriculum at Fiji National University annual since 2014 and at Kathmandu University in Nepal annually since 2017 in conjunction with Interplast Australia and New Zealand. This course is designed for physiotherapy students and physiotherapist from all pacific islands and aims to ensure all graduates returning to isolated communities have skills to treat burns and hand trauma. The scope of this course includes prevention of disability, improved health and wellbeing, reduction of poverty and inequality by improving local access to effective



and urgent treatment in line with WHO sustainable development goals.

Together with Interplast she has implemented outreach programmes since 2000. This has included twice yearly surgical programmes to hospitals in Fiji and 2 programmes to Kirtipur Burns Hospital, Nepal as a team member volunteer to assist with assessment, treatment, provision of equipment, supplies, teaching and protocol resources, clinic setup, mentoring of local staff both during the visit and ongoing on a weekly basis for 2 therapists between visits.

Jenny's ongoing relationship with Interplast also included volunteer executive and planning roles, including being a member of the Clinical Governance Committee, Clinical Lead for Online Education particularly focussed on webinar topic and presentations and Coordinator for Allied Health in the Pacific region.

In 2018 the IFSHT awarded Jenny a teaching grant for her teaching in Nepal. The scope of her work in Nepal aimed to promote extended scope of practice as the only allied health profession in the Pacific and parts of Asia through: clinical reasoning and assessment skills, evidence based clinical practice, orthosis and burns compression garment fabrication skills using local resources, discharge planning, burns prevention programmes, outcome measurement, professional confidence in the treatment and rehabilitation of hand and upper limb trauma and burns to the whole body to prevent disability, leadership skill to champion high quality practice within their own community. In 2021 Jenny facilitated IFSHT corresponding membership for Fiji in the absence of country association.

Jenny maintains membership with the Australian Hand Therapy Association, which she served as the president between 1994-1996 and has been a member since the inception of this association in 1983. She also serves as a Physiotherapy Research Foundation grant reviewer with the Australian Physiotherapy Association which she has held

membership with since 1981. Other roles have included author and presenter of professional development courses and serving as state treasurer between 1983-85. Jenny also maintains membership with the Australian and New Zealand Burn Association (ANSBA).

In 2019 Jenny was awarded the Member of the Order of Australia which is a national honour awarded on Australia Day by the Governor General and Australian Government for distinguished service for "Services to Physiotherapy and overseas volunteer work and teaching".

Jenny has many publications, keynote and workshop presentations both nationally and internationally that she has participated in and completed.

Jenny's contribution to the ongoing Hand and upper limb management as well as burn management is noteworthy and her participation in volunteer work for over 21 years is extraordinary. She is a role model and mentor for so many and is very deserving of this lifetime achievement award awarded by the IFSHT.



## Sandra Artzberger

Sandra commenced her Occupational Therapy career over 50 years ago and welcomed retirement in 2014. She has worn many hats in her career including private practice hand therapist, graduate level college instructor, author and a national/international lecturer in the field of hand therapy and lymphedema treatment. Her noteworthy contribution to this field is Manual (O)Edema Mobilisation (MEM).

Sandra was certified in Manual Lymphatic Treatment in 1995 and established the first lymphedema clinic in Wisconsin with colleagues. This led to the development of her MEM technique, as she combined her years of hand therapy experience with her lymphatic knowledge. She has maintained an ongoing clinical caseload throughout her career utilising her knowledge in the arenas of hand therapy and lymphedema.

Sandra has been contracted to contribute to national continuing education workshops for degree therapists by many agencies including Keep Pace Inc, Excellcare, Educational Resources, Rehabilitation Institute of Chicago, Rehab. Education, University of Wisconsin Milwaukee, Hand Therapy Consulting and Cedar Haven Rehabilitation Agency. She has also been invited to professional organisations such as state hand therapy study groups, and educational institutions including OT programs at Nova Southeastern University and Columbia University New York.

Her scope of travel as an invited speaker at national and international conferences has taken her to Denmark, South Africa, Turkey, Canada, Scotland, Australia and New Zealand. Sandra has presented at 5 IFSHT meetings starting in 1998.

Sandra's professional Memberships include the American occupational therapy Association,



Wisconsin Occupational Therapy Association, American Society of Hand Therapists (Charter Active Member), Certified Occupational Therapist in state of Wisconsin, Certified Hand Therapist (1992), Member of the National Lymphedema Network.

Within the state of Wisconsin, she has been recognised with many awards of appreciation and for pioneering in the practice of hand Therapy and well as for her ongoing contributions in professional the continuing education.

Sandra has provided ongoing written publications as early as 1997 when she published an article about Edema Control: New Perspectives in the AOTA Physical Disabilities Special Interest Section Quarterly. Since then, her contribution to ongoing literature through articles and book chapters has continued. She is also published within the well-known text Rehabilitation of the Hand and Upper Extremity in multiple editions.

Sandra's teaching style is practical, demonstrative and highlights her area of expertise and knowledge. She is a very deserving recipient of the IFSHT lifetime achievement awards and her contributions to the profession are and will continue to be ongoing into the future.

## VOLUNTEER:

# Hand in Hand with Ukraine

There are a number of opportunities for hand therapists to volunteer their time for hand therapy service delivery and/or education. Some are listed on the IFSHT website [here](#). We will feature them in this section of REACH.

In December 2021 a group of hand surgeons and physiotherapists met with the intention of starting the specialty of hand therapy in Ukraine. Before this could begin, war broke out.

Ukrainian hospitals are now managing extensive hand injuries from, gun shots, falling building materials and broken glass. They are also continuing to manage injuries sustained in sport, work and general life along with management of routine conditions such as Dequervain's, Dupuytren's Disease, arthritis and carpal tunnel syndrome. There are no specialist hand therapists in Ukraine to help maximise outcome for these victims. Physiotherapists and ergotherapists are trying to treat these victims with no speciality training at all. On many occasions rehabilitation is being provided by hand surgeons.

A successful series of webinars has been run for hand surgeons by the British Society of Surgery of the Hand. Due to the success of these webinars and discussions between Nicola Goldsmith and the key surgeons in Ukraine, the initiative to develop hand therapy skills and knowledge Ukraine was conceptualised.

At the International Federation of Societies of Hand Therapists congress held in London in June 2022, Nicola launched the initiative and subsequently had 50 therapists from around the world volunteer their time and expertise to deliver weekly webinars.

These series of webinars have now commenced and planned fortnightly for the remainder of the 2022. We have a consistent group of therapists and surgeons joining and learning from these. In January 2022 these webinars will be weekly and will run through until August 2023. The webinars written material is being translated for attendees.



The Hand in Hand with Ukraine team consists of Nicola Goldsmith, Christy Fowler, Anna Andryushuk, Andreii Lysak, Irina Kondrashova and Ross Barnaby. In the past 4 months the team has successfully built and launched a website and social media presence. The website will host the back catalogues of all webinars for registered participants, along with additional resources to support learning and growth. The ability to build this website and provide translated material is the only possible through the generous donations. If you can offer any financial support you can so through the website. [www.handinhandukraine.org.uk](http://www.handinhandukraine.org.uk)

We welcome hand therapists willing to deliver the content of the webinars. If you can offer this time, please register on website [www.handinhandukraine.org.uk](http://www.handinhandukraine.org.uk)



## SPOTLIGHT ON: Swiss Society of Hand Rehabilitation

The Swiss Society for Hand Rehabilitation (SGHR/SSRM) was founded on March 1, 1990 by 5 hand therapists in Lausanne. As Switzerland is multilingual, the society unites therapists speaking French, German and Italian.

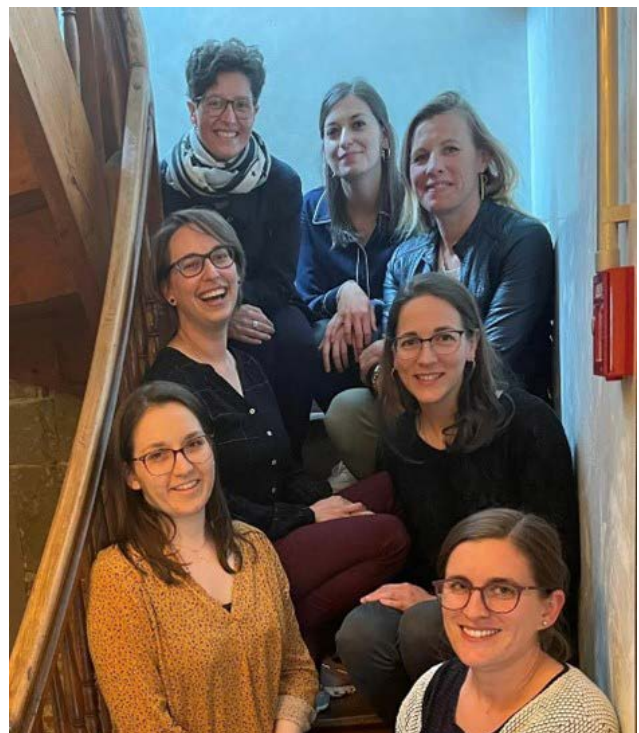
Today, the SGHR/SSRM has over 410 members, of which almost 30 are physiotherapists and 370 occupational therapists. All of them work in a public or private hospital or in a private practice.

The first national congress organised by the SGHR/SSRM was held in 1992. Already 2 years later, a joint congress was organised in collaboration with the SGH/SSCM (Swiss Society for Hand Surgery). Since 1994, yearly national congresses have been organised with the SGH/SSCM. The next one will take place in Thun on November 24 and 25, 2022 and the main topic is "360° quality".

The SGHR/SSRM actively participated in the organisation of the 3-country congresses (Germany, Austria and Switzerland) in 2001 and 2004, and organised the European congress "Eurohand" in Lausanne in 2008. In 2020, SGHR/SSRM representatives organised the joint European FESSH-EFSHT congress in Basel. Due to Covid-19, the congress first had to be postponed and then held entirely online as the very first "EFSHT Online! Week". It was a complete success, with over 400 therapists participating from all over the world! As a member of the European (EFSHT) and international (IFSHT) hand therapy federations, numerous members got personally involved and represent Switzerland in committees and project groups.

Education and training in hand therapy has always been a major concern of the society. Thus, courses were soon offered and coordinated by the SGHR/SSRM, which are still successfully carried out in the French- and German-speaking parts of Switzerland.

From the very beginning, the "Info-Contact", the publication of the SGHR/SSRM, has been a central



*SGHR Committee:*

*From left to right, beginning at the back to the front Ursula Osterwalder, Pauline Chèvre, Barbara Roland, Patricia Kammermann, Esther Marthaler, Julie Dziwornu & Stéphanie Rosca-Furrer*

part of the Society. As a bulletin for the news of the society, the Info-Contact was initially printed at home by members of the executive committee and sent to the members. With the increasing number of members and the publication of technical articles, the journal developed more and more professionally, until it was redesigned and renamed in 2006. Now it reaches a circulation of about 450 copies twice a year as "Promanu".

A major project has been and still is the recognised certification as a hand therapist in Switzerland. In 1995, a commission was formed with the goal of further training for hand therapists. After intensive work, the first hand therapists were certified in 2003 and 2005 by exam. Changes in the educational landscape caused the suspension of this certification in 2006. A new training profile was developed by a working group including representatives of the universities. Thus, the Certificate of Advanced Studies (CAS) in Hand Therapy was created in collaboration with the ZHAW (Zurich University of Applied Sciences), the successful completion of which (including a

presentation at the congress and a minimum of 2 years of professional experience) leads to a direct certification as hand therapist. Selected courses from other universities are also recognised. After 10 years, proof of active commitment in the field of hand therapy is required to renew the certification.

For 32 years, members of the SGHR/SSRM have been involved in numerous larger and smaller projects. Thanks to the courage and commitment of some hand therapists and thanks to many dedicated and motivated members, the SGHR/SSRM can look back on an eventful and fruitful history and look forward to an exciting and eventful future full of energy and ideas.



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