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ABSTRACT

The objective of this editorial is to update the readers of Journal of Physical Therapy, an example from PubMed- a database from National Library of Medicine (USA) on the evolution of physical therapy as a profession. Historical milestones for the field are reviewed and future implications are provided.

Key words: professional autonomy, primary care practice, first-contact practice, direct access, open access service.

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History:

As we begin our walk, along the pages of history in Pubmed, the first publication was in 1910, by Alfred W Perry who described the importance of physical therapy- manual evacuation technique and diet therapy on maintaining the normal shape of abdomen.

Definition of physical therapy:

Harvey defined as according to California association of physiotherapists, the then definition of physiotherapy and physiotherapists as shown in figure-1. The definition signified referral-based practice pattern of physical therapy then existed. The phrases, ‘prescribed by doctors of medicine’, ‘administered under physician’s direction’ by ‘educated and trained “technical” assistants’ are quite worth mentioning.

The ‘art’ of physical therapy:

Over the years, the ‘art’ of physical therapy was increasingly been recognized. Behneman pointed out the lay and professional perspective of physical therapy as shown in figure-2. The last line there deserves special mentioning of the importance of thinking process for decision-making in physical therapy and hands-on skill of physical therapist.

Development of physical therapy over the years:

Ms. Christine E Graham, as an editor of Journal of Canadian Physiotherapy Association (the then name for Physiotherapy Canada journal) in 1940 provided reflection into practice and entailed the development of the field as a widely indicated and growing contribution in management of medical and surgical conditions. The words, 'medicine now….at its disposal...in the field of physical therapy' though was prevalent (figure-3).

Medically directed or ‘at its disposal’ physical therapy evolved into ‘under competent medical supervision and instruction’ in 1951 (figure-4).

Max Minuck in 1953 detailed the role of pre- and post-operative physiotherapy and indicated its application in prevention of complications due to immobilization, deconditioning and surgical procedures (figure-5).

Key points and pre-publication history of this article is available at the end of the paper.
Editorial

Figure-1:

Physiotherapy is defined as "a group of physical therapeutic procedures to be prescribed by doctors of medicine and administered under the physician's direction by specially educated and trained technical assistants." Physiotherapists, in the meaning of the California organization, are "the educated, trained technical assistants to the members of the medical profession, who subscribe to and are imbued with the ethics, ideals and spirit of service that inspire and govern the physician in the practice of the healing art."

Figure-2:

In the mind of the public, the term "physical therapy" signifies electricity, lamps and machinery of various sorts. In the mind of the physician, however, its true definition remains that of body mechanics, massage, and postural training. His conception of a good technician is that of an intelligent graduate in nursing or physical education, with added training in physics, physiology, anatomy, and the fundamentals of body mechanics. Ninety per cent of honest physical therapy needs only good brains and good hands for its execution.

Figure-3:

Looking back, one can see the growth of recognition by the medical profession of this branch of therapeutics. Medicine now has a legitimate and useful weapon at its disposal against the inroads of charlatanism in the field of physical therapy, which, with the passing of the years, has been expanded and defined.
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Physiotherapy grew and catered to multidisciplinary needs, and by around 1970, started working 24-hours a day. But the responsibility still rested with doctors (figure-6). Freedman and his colleagues in 1975 pointed out that there was an improved recognition of role of physiotherapist as member of primary care team (figure-7). Physiotherapy grew and catered to multidisciplinary needs, and by around 1970, started working 24-hours a day. But the responsibility still rested with doctors (figure-6). Freedman and his colleagues in 1975 pointed out that there was an improved recognition of role of physiotherapist as member of primary care team (figure-7).

David C Blair denied independent practice for physical therapists and he said such a functioning would lead to decline in patients' quality of care. However, he added that physicians trained in physical methods must guide physical therapy treatments (figures 8a, 8b). There was increasing trend towards independence in decision-making by physical therapists, and a direct open access in provision of therapeutic services (figure-10).

The range of physiotherapy has expanded greatly since its inception, and it has as its function the prevention or correction of many altered physiological states.

The value of physiotherapy for patients in rheumatology, orthopaedic, neurology, and intensive care units is not questioned, and often a demand for a 24-hour service is being met. Nevertheless, the responsibility for the efficient use of physiotherapists' time rests with doctors.

We feel that we have established a definite place for a physiotherapist as a member of the team providing primary medical care.

Given the physiotherapist's enthusiasm it should be possible for similar schemes to work in most practices. As a result of our experience during the past two years it seems to us desirable that free physiotherapy should eventually be provided by the National Health Service in the same way as medical and nursing care.

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Gentle et al in their controlled trial of open-access physiotherapy versus control care showed that patients receiving open-access PT services recovered more rapidly thus supporting the use of such services (figure-11).  

In a survey by Uili et al, physicians preferred a prescriptive relationship when referring patients to physical therapists, and they most often selected "technical" procedures traditionally associated with the profession rather than "professional" procedures when referring patients to physical therapy. Those practicing medicine in their specialty 10 years or more were more conservative in their referral preferences than those in practice less than 10 years (figure 12).

Partridge found increased utilization of physical therapy services as community level (figure 13).  

Durant et al found that a majority of patients indicated they would seek physical therapy services without referral if they were available. Physical therapists were cited as frequently as all other health care professionals combined as the practitioners providing the most thorough evaluation. Physical therapists were cited far more often than other health care professionals combined as the practitioners providing the best information about the control of symptoms (figure-14).

O’Cathain opined on advantages of on-site physiotherapy compared to direct-access services as in figure-16.  

Physical therapy services expanded further and inclusion of PT in accident and emergency departments also reduced waiting times and improved patient care and recovery.

Waldman explained the conflicts of interest that existed between physicians and physical therapists so much that physicians tend to refer patients to their own ‘physician-owned’ physical therapy clinics.

Direct access episodes were found to be shorter, encompassed fewer numbers of services, and were less costly than those classified as physician referral episodes.

Jensen et al witnessed continuous growth in expert practice of physical therapy which involved 4 dimensions: (1) a dynamic, multidimensional knowledge base that is patient-centered and evolves through therapist reflection, (2) a clinical reasoning process that is embedded in a collaborative, problem-solving venture with the patient, (3) a central focus on movement assessment linked to patient function, and (4) consistent virtues seen in caring and commitment to patients.

Physical therapy ventured into veterinary medical practice. Physical therapy started challenging the then survived myths with establishing of new evidence. Physical therapy managers’ top-ranked component categories for physical therapists entering clinical practice across the 3 scales (importance, knowledge, and skill) of APTA’s LAMP document were communication, professional involvement and ethical practice, delegation and supervision, stress management, reimbursement sources, time management, and health care industry scanning.

With the use of varied strategies of clinical reasoning in their decision-making, physical therapists could by this time differentiate patients based on their clinical presentation, decide whether to provide physical therapy treatments or provide medical referral.
In summary, physiotherapists who have a code of ethics that allows them to be independent of the medical model and function can only contribute in the long-term to a decrease in the quality of patient care. The guidance must come from physicians trained in physical methods of treatment and interested in teaching.

Figures-8a, 8b.

Having physiotherapists as part of the primary health care team means that general practitioners are able to offer their patients physiotherapy more directly when they consider this appropriate. Both developments mean greater flexibility in access to physiotherapy and allow the physiotherapy services to respond more efficiently to the needs of all patients in their district.

Figure-9
Physiotherapists may decline to treat a patient if in their opinion treatment is either contraindicated or unlikely to be helpful in the light of the information given. They may also delay treatment if insufficient information is given to assess the patient properly.

An open access service has reduced the pressure on consultant orthopaedic surgeons and enabled patients to receive treatment quickly.

We commend open access to physiotherapy services, believing that it has done much to reduce unnecessary suffering to patients.

It will be seen that three of the four benefits claimed for an open-access physiotherapy service have been supported: patients made less use of consultant outpatient clinics, they received physiotherapy promptly, and they recovered more rapidly.

These research findings support . . . . . . . . . . . . . . . . . . . . that physicians perceive and utilize physical therapists primarily as technicians rather than professional colleagues.
Physiotherapists in some parts of the county see patients in health centres and at general practice premises, mainly for the treatment of soft tissue injuries and conditions. Advice and treatment without delay may prevent the development of longer term disabilities and facilitate an early return to work for the patients.

It is essential, with the present emphasis on care in the community, that physiotherapy services are made available when they are needed.

Figure-13

It has been suggested that “no other health professional has patient access to its services so severely limited, and few other health professions are so demonstrably well qualified for practice without referral.”4 The respondents in this survey expressed confidence in their physical therapists’ evaluation skills and knowledge of how to control their symptoms. A majority indicated support of direct access and a willingness to use physical therapy services without referral.
“Direct access” to physical therapy services refers to evaluation and treatment of patients by physical therapists without referral from a physician or other health care practitioner. As of September 1989, 24 states have permitted direct access to physical therapy services.

Since the late 1970s when physiotherapists in Australia were first able ethically to undertake primary contact practice, ie to accept patients without medical referral, private sector practice has developed and flourished. It is estimated that, annually, there are some 5 million primary contact attendances occur in this way. However, while many of the patients presenting to public sector Emergency Departments have similar conditions, primary care practice has been slow to evolve in that area.

physical therapists are certified under their respective states and their educational qualifications are equivalent to a graduate of a professional medicine degree program and exceed the education of both the nurse practitioner and physician assistant, who are health professionals and are qualified to provide referral.
Professional autonomy includes control over the decisions and procedures related to one’s work (technical autonomy) and control over the economic resources necessary to complete one’s work (socioeconomic autonomy). Professional autonomy for physical therapists is increasing as medical dominance has declined but is limited by the trends of rationalization and deprofessionalization in healthcare.  

Nall rightly put forth that physical therapists undertook primary care practice, i.e., to accept patients without medical referral. See figure-17. Figure-18 shows the recognition of physical therapists by TRICARE as highly qualified and proficient members of healthcare team, to be considered on par with medical professional, to be as healthcare consultants providing referral.

The hard-earned autonomy and professional direct access was achieved through dedicated community-based services and interprofessional teamwork. Physical therapists need to take this message home if they need to improve from where they are. Rather than being complacent about today’s position, we need to reflect back on the milestones and keep working on facing the challenges and opportunities for therapeutic services ahead in future. As the decision-making shifts towards an evidence-informed paradigm, the field of physical therapy needs to shift towards a professionalism-based paradigm. Such a shift is the need of the moment and of the future.

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CONFLICTS OF INTEREST

None identified and/or declared.

REFERENCES


