Physiotherapists in emergency departments: responsibilities, accountability and education

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Abstract

Emergency physiotherapy roles have evolved within the UK and are increasingly being adopted in Australia in response to a need for greater workforce flexibility and improved service provision to meet growing patient demand. This paper discusses the need for the physiotherapy profession to develop evidence-based regulatory, ethical and educative frameworks to keep pace with the changing clinical environment and service delivery in emergency departments.

Definitions of Emergency Physiotherapy as either advanced practice or extended scope of practice are identified, and the implications for both regulation of practice and education are highlighted. Suggestions for education in areas of clinical skills, ethical understanding and legal and professional knowledge are highlighted as important areas to support physiotherapists moving into this area of practice.

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Physiotherapists apply specialised knowledge and skills in clinical reasoning and treatment in clinical settings from emergency departments to long-term chronic care [1]. Two key features of physiotherapy practice, are high level clinical reasoning [2,3] and a capacity to respond and evolve to changes in societal expectations of healthcare delivery. These features are driving the profession to move beyond building individual professional autonomy and towards partnerships with others in health systems, to meet the changing needs of patients and health delivery models [1,4]. This paper focuses on the changing role and implications of physiotherapists in the emergency department setting.

Within Australia ‘Emergency Physiotherapy’ (EP) has been defined as a clinician working in an acute hospital emergency department (ED) managing patients with acute and sub-acute musculoskeletal conditions either autonomously or in conjunction with other medical staff [5]. In the United Kingdom, over the last decade, a demand driven push to modernise the National Health Service (NHS) and increase workforce flexibility has facilitated the emergence of the EP role [6]. In Australia, patients presenting in EDs have increased by 5% per year since 2003 with 77% being less or non-urgent conditions [7]. This increasing demand has been recognised as unsustainable, requiring new and innovative methods of service delivery to meet the needs of the presenting population [8]. One such innovation is physiotherapists in the ED health team.

Emerging evidence suggests EP is a viable option for patients with less urgent conditions such as, soft tissue injuries, minor fractures and mobility and balance problems [5,9–11]. EP enables release of medical staff for more critical interventions [12], fewer stops in the patient journey [13], reduced patient waiting time and cubicle occupancy times [14], higher patient satisfaction ratings for EP’s compared to other medical professionals and nurse practitioners [12,14] and more efficient assessment and management [13]. Professional benefits include improved retention of senior
physiotherapy staff due to creation of career pathways into advanced practice and extended scope roles [6].

However the EP role has been driven by a political need to reduce waiting times rather than to improve patient outcomes, therefore systematic evaluation of patients’ perspectives of the role or how to best educate physiotherapists in this role has been limited [15]. While there has been no reporting of adverse incidents [6], and some evidence that EPs are at least equivalent to hospital medical staff with respect to screening for and identifying significant injuries and making appropriate referrals to outpatient clinics or specialists [12], long term safety and effectiveness has not been thoroughly investigated. It is possible, for example, that evidence of higher patient satisfaction associated with EP, may be explained by decreased waiting times rather than physiotherapy interventions, and time benefits may have resulted from introducing an additional employee into ED, not specifically an EP [12]

This paper addresses three questions arising from the EP role: (1) how does EP fit within the broad skill set and scope of contemporary physiotherapy practice?; (2) how does EP fit within current regulatory frameworks guiding practice?; (3) what level of education and experience is required to support EP?

In this paper, we aim to stimulate discussion around these questions by describing EP within Australia and how it differs from traditional physiotherapist/patient treatment encounters. We then discuss implications of EP for professional regulatory frameworks, and how EP roles should trigger the physiotherapy profession and academics to ensure curricula keeps pace with and effectively underpins the landscape and conditions of the clinical workplace.

Overview: the development of physiotherapy in Australian Emergency Departments

Historically, the ED is defined as “the dedicated area in a public hospital that is organised and administered to provide emergency care to those in the community who perceive the need for or are in need of acute or urgent care” [16, p. 199]. In Australia, EDs are legally required to provide basic health care, 24 hours a day regardless of the patients ability to pay and whether their need represents an emergency or not [17]. There is no restriction to the number of people presenting to an ED and there is a legal and ethical responsibility for all patients to be seen [18]. There is an increasing and uncapped demand for emergency care. The quality of ED care is threatened through delays in diagnosis and treatment, increased risk of medical errors, a reduction in quality of care and an increased likelihood of poor patient outcomes [19] which is further exacerbated by an increasing focus on point of care testing and treatment interventions within ED followed by outpatient management to accelerate patient turnover and reduce hospital admission rates [8]. Thus a re-evaluation of traditional clinician skill sets and skill mix is required [20].

EP as a subset of contemporary physiotherapy practice

In Australia EP has focused on two key roles which are subsets of assessment, diagnosis and clinical reasoning skills [3] care coordination and soft tissue injury specialisation [5]. In care coordination, physiotherapists use their clinical reasoning skills to screen, assess and refer patients to prevent unnecessary hospital admissions [5]. This includes acting as a secondary contact practitioner to assess suitability for discharge with respect to mobility status and falls risk, following referral by medical staff [13]. It also encompasses independent assessment and treatment in areas such as vestibular, cardio-respiratory, neurology and musculoskeletal conditions [5]. This role uses what Christensen et al. [21] refer to, as high level autonomous clinical reasoning capacity, applied to the specific needs emerging from different models of health care delivery, in this case the emergency setting.

In soft tissue injury specialisation, EPs act as musculoskeletal injury specialists (also referred to as primary contact physiotherapists or EP practitioners) who assess, diagnose and provide specialist clinical services [5,22]. While assessment and diagnosis are common to all physiotherapy roles, the musculoskeletal injury specialist is responsible for an expanded task set that includes requesting and interpreting radiology; applying plaster; managing minor wounds and fractures; assessing analgesia needs, and referring to other medical and allied health disciplines and applying an expanded range of therapeutic interventions [5,9].

EP also presents as a distinctive work environment. The traditional practices of diagnosis, assessment and discharge planning are conducted in a time pressured multi-disciplinary environment, where team relationships must be developed quickly rather than being built over time, and where responsibilities and referrals are fast tracked [23]. In this setting, team relationships are less hierarchical and physiotherapists independently contribute diagnostic, management and discharge planning information. [5].

In Australia, one important and still unresolved debate about EP is whether it represents an extension of the core scope of physiotherapy practice, or whether it is a form of advanced practice requiring an advanced level of already established physiotherapy clinical skills [5,13]. This debate has important implications for defining standards of care and associated educational preparation.

The scope of practice of physiotherapy in Australia is defined as the rules, regulations, boundaries and context within which a qualified practitioner with appropriate training, knowledge and experience may practice in a specifically defined field [24,25]. Professional scope is determined by legislation and standards whilst individual scope is determined by organisational policy, culture, individual competence, knowledge and skill [25]. Advanced practice involves applying clinical skills, reasoning, knowledge and experience in
areas of practice previously performed by other professions or in new clinical areas [24–26]. The advanced practice argument proposes that within Australia, the EP role reflects many tasks already undertaken by private practice physiotherapists, including first contact management. On this basis, the ‘extended’ nature of EP discussed within the literature may relate more to the mode of delivery rather than specific tasks [23]. Extended scope of practice (ESP) in Australia requires clinical specialisation or expertise beyond currently recognised scope of practice [13,24,25]. The argument for EP representing a form of extended scope has largely occurred in the UK where practitioners have previously been defined as clinical specialists working beyond recognised scope of physiotherapy practice in innovative or non-traditional roles [6,27]. However in 2008 there was a fundamental shift in this situation where the scope of physiotherapy practice in the UK was revised to be defined as “any activity undertaken by an individual physiotherapist that may be situated within the four pillars of physiotherapy practice where the individual is educated, trained and competent to perform that activity”. Such activities should be linked to existing or emerging occupational and/or practice frameworks acknowledged by the profession, and be supported by a body of evidence [28]. This resulted in tasks previously considered extended scope now being classified as advanced practice.

Unlike the early UK interpretation, the Australian Physiotherapy Association (APA) suggest current EP roles constitute advanced practice, due to application of advanced clinical reasoning skills, rather than extension of scope [29]. However in a 2006 review the APA identified potential areas of skill expansion into extended scope of practice tasks including: (1) extended diagnostics; requesting and interpreting diagnostic tests such as blood tests, X-rays, imaging scans; (2) investigative procedures such as bronchoscopes; (3) extended therapeutics; invasive techniques such as injections or joint aspirations; (4) other tasks such as wound care and plastering; (5) limited prescribing rights; and (6) extended practice consultation: determining onward clinical referral i.e. to specialist-level-physicians and direct listing for surgery [13].

Ongoing uncertainty about defining EP as either extended scope or advanced practice means there is ongoing uncertainty for EPs. For example, plastering, minor wound care, requesting and interpretation of x-rays, and extended practice consultation are already being performed by EPs and other physiotherapists, to differing degrees, throughout Australia [5]. Plastering occurs as part of current practice, particularly within New South Wales [30], and wound care is performed to varying degrees by sports physiotherapists and those working with burns [31].

Further uncertainty concerning the nature and scope of EP work arises from both funding and legislative anomalies and their recognition of different aspects of EP. Australian physiotherapists, working within current scope of practice, can legally order diagnostic tests such as X-ray, ultrasound, CT and MRI [32]. While this area of practice is supported by evidence that physiotherapists have the clinical reasoning capacity to appropriately access radiology services providing measurable patient care benefits [33,34] a lack of recognition within the Australian Medicare funding schedule means considerably lower, or non-existent refundable benefits, compared to other health professions [32].

Although it is unlikely that the debate about whether EP represents extended scope or advanced practice will be settled in the short term, if emergency physiotherapy is categorised as extended scope of practise, then clinicians are practising outside the Australian legal and regulatory frameworks of physiotherapy. Australian physiotherapy professional and regulatory bodies should therefore be drawing from knowledge and expertise of the UK experience [6]. If EP is classed as a form of advanced practice, then further definition is required relative to other areas of physiotherapy practice.

Emergency physiotherapy role and the regulatory framework

As primary healthcare practitioners, physiotherapists operate within a layered regulatory framework including notions of professionalism, codes of ethics and the law [35–37]. Notions of professionalism broadly include communication skills, ethics knowledge, ongoing commitment to learning and awareness of relevant laws for clinical practice [36,38].

Professional codes of ethics provide more definitive guidelines for practice, although they also require specification in different contexts and circumstances. The ethical governance of Australian physiotherapists derives from the code of conduct of the Australian Physiotherapy Profession (APA) [39] and from the Physiotherapy Board of Australia, as the statutory regulatory authority.

The Physiotherapy Board of Australia was established, along with 9 other National Boards (Chiropractors, dentists, nurses, doctors, optometrists, osteopaths, pharmacists, podiatrists and psychologists) in July 2010 under the Health Practitioner Regulation National Law Act (National Law). These national boards have collaborated, to align standards, codes, and guidelines common to each profession specifying particular ethical issues arising in different parts of the health system such as ED.

The current definition of practice, adopted by most boards (including physiotherapy) is to refer to any role ‘in which the individual uses their skills and knowledge as a health practitioner in their profession [40].’ This definition is purposefully broad to allow for innovative responses to the evolving nature of health care and health professional practice. National law provides for protection of title rather than defining scope of practice. This means EPs are not restricted by the statutory definition of their practice, as long they use their knowledge and skills in safe, effective delivery of services in their profession. This less restrictive regulatory framework promotes opportunities for expansion into EP roles. It also means that
physiotherapists must be able to recognise and translate specific standards and competencies relevant to new areas of clinical practice.

Lahey and Currie [41] suggest professionals expanding into new areas of inter-professional practice have potentially increased legal exposure as they may not be equipped, either through a lack of legal precedent or competency standards set by professions to examine and determine responsibility and liability. They also suggest that lack of clarity in professional roles and scope of practice may lead to “turff battles” in service delivery, which reinforce conservative approaches such as physician dominance over inter-professional collaboration [41, p. 210].

More defined standards of care are imposed on health professionals, including physiotherapists, by a duty of care defined through case law [42]. Since 1932 the common law of the UK and Australia Donoghue v Stevenson [1932] AC 562 [43] has recognised the health practitioner as the ‘neighbour’ of the patient, owing them the duty to take reasonable care. In England, in the case of Bolam v Friern Hospital Management Committee [1957] 1 WLR 582 [44] the House of Lords held that the standard of care required is that of a reasonable practitioner of similar experience. Applied to standards of information disclosure, the Australian courts have taken a different view since the decision of the High court in Rogers v Whitaker (at 633), where the standard of care is defined according to reasonable patient would want to know, rather than what a reasonable doctor would want to tell. Rogers v Whitaker (1992).

The challenge for health practitioners in either jurisdiction is that common law is universally recognised as evolving as society itself evolves [45], complicated in the English context by interactions with the European Convention on Human Rights (ECHR) [46]. This means that precise delineation of boundaries of the duty and standards whilst reasonably clearly established, always remain open to question by a disaffected patient.

Medical ethics literature and philosophical ethics are further sources of knowledge that assist in providing rationales for clinical and ethical decision-making required by physiotherapists in traditional and emerging practice areas [47]. Some authors have focused on ethical dimensions of practice in specific settings i.e. rehabilitation [48]; private practice [35] and paediatrics [49]. Recently, there has been an increasing acknowledgement of the importance of physiotherapy engagement with different models of health and illness [50] and corresponding ethical obligations of physiotherapists to respond to issues of justice and access in health care [4, 50].

However literature focusing on ethical dimensions of EP is yet to emerge. Questions requiring both empirical and normative attention include (1) how EPs can best inform patients about treatment options, (2) how and when to refer to others; and (3) what constitutes a patient’s best interests when screening their presenting problem and referring on to other services rather than the more familiar physiotherapist/patient interaction role of assessment, examination and treatment? Being seen by a physiotherapist in emergency can be an unexpected event for patients as most expect to be assessed by a doctor [51]. Weatherly and Hourigan [52] for example, found a significant proportion of EP’s didn’t inform patients that they would not see a medical doctor.

The law (Rogers v Whitaker) in Australia has set clear standards for informing patients about nature of treatment including risks, benefits and alternatives, and has been applied in the context of cervical manipulation [53]. This same level of scrutiny about amount and type of information exchange is also required for the complex and dynamic ED environment.

More broadly, the EP role challenges therapists to review how they position and define themselves as health practitioners. Moving into new spheres of practice has a potential impact on the culture and ethos of physiotherapy work. In America, Australia and England, physiotherapists have worked at establishing and maintaining a professional and scientific standard in line with their medical colleagues. A strong professional focus to date, has been on developing practice validity and building an evidence base for physiotherapy interventions [54] however EP requires clinical reasoning in a multidisciplinary context with reference to different treatment pathways and types of intervention. Expansion into multidisciplinary settings with changing and sometimes less demarcated roles, means physiotherapists may need to review and reflect on their professional roles and what counts as effective practice within the health care system.

**Emergency physiotherapy role and education**

The physiotherapy ethos and practice paradigm has developed from educational activities where propositional facts and practical skills framed goals and intentions of treatment [55]. The integral role of education in shaping practice is significant when considering how to develop curricula supporting expansion of physiotherapists into new workplace settings. In 2004, the APA recommended advanced practice physiotherapists have a minimum of 5 years clinical experience post entry-level physiotherapy qualification, of which 3 years should be within the relevant specialist area. Completion of APA specialisation training to ‘titled’ member level in relevant specialist areas, and/or completion of further post-graduate study and/or advanced training in relevant specialist areas is stated as desirable [55]. Currently there is no pathway to titled membership of the APA for emergency physiotherapy and therefore no pathway to specialisation which could more clearly define the range of specialist skills. The only post graduate options available to support the advanced practice role are musculoskeletal post graduate certificates or masters [23] which are targeted more towards outpatient and private practice settings rather than EP roles. EP’s are therefore accessing a variety of short courses such as spinal, vestibular, plastering and sports [23].
Other types of educational support such as those developed in medical practice [56] are provided by workplaces as onsite training and individually based clinical practice supervision and support. Certification where appropriate, will also be required in the absence of existing formal training, to ensure practitioners can competently and safely undertake clinical demands of delegated medical tasks [6,13]. However these ad hoc courses and certificates will not achieve standardisation across health care institutions and may create problems in establishing a clear underpinning educational structure. This may in turn, make it difficult to evaluate whether physiotherapists working in ED have discharged their legal and ethical duty of care.

The response from professions, regulators and institutions should include establishing systems to coordinate individual and health team approaches in ED; developing policies to monitor and evaluate changing professional roles; and instituting new standards and approaches to documentation that ensures information is shared between all health providers in a comprehensive and timely way [41].

Finally the role of education should assist in promoting critical reflection and evaluation of how individual physiotherapists and, more broadly, the profession as a whole are positioning themselves within the broader health system framework. In particular physiotherapists need to be encouraged to perceive themselves as moral agents to facilitate awareness of how to interpret and apply ethical and legal dimensions in new areas of clinical practice [57].

Conclusion

In Australia, debate about whether Emergency Physiotherapy should be defined as either advanced practice or extended scope is ongoing. This debate extends to uncertainty about regulation and highlights a need for education to clarify and support this area of clinical practice. This paper provides an overview of role definitions for Australian EPs and implications of this new area of practice, for regulation and education. We suggest there is a need for the physiotherapy profession to develop evidence-based regulatory, ethical and educative frameworks to keep pace with the changing clinical environment and service delivery in emergency departments.

Ethical approval: Not required.

Conflict of interest: None.

References


[44] Bolam V Friern Hospital Management Committee, 1 WLR 582; 1957.


