

## Advancing Physical Therapy Practice: The Accountable Practitioner

John D. Childs, PT, PhD, MBA, OCS, FAAOMPT<sup>1</sup>

Julie M. Whitman, PT, DSc, OCS, FAAOMPT<sup>2</sup>

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**W**e are excited to introduce 2 special issues in the *Journal* that feature articles relevant to direct access physical therapist practice. The rationale for covering these topics in the physical therapy literature is clear: the American Physical Therapy Association's (APTA's) Vision 2020 states that, "By 2020, physical therapy will be provided by physical therapists who are doctors of physical therapy, recognized by consumers and other health care professionals as the practitioners of choice to whom consumers have direct access for the diagnosis of, interventions for, and prevention of impairments, functional limitations, and disabilities related to movement, function, and health."<sup>1</sup> To achieve this goal, APTA's Board of Directors suggests that we should focus our efforts on 5 key areas: professionalism, direct access, the doctor of physical therapy, evidence-based practice, and practitioner of choice.<sup>5</sup> Because a majority of first professional degree programs have now transitioned to the professional doctoral degree and physical therapists can provide direct access care in 39 states, it is clear that we are quickly moving toward the Vision 2020. However, it would be helpful to reflect on where we are as a profession and what it is, exactly, that we want in our journey toward the goals set forth by our national organization.

Since the inception of our profession, we have been transitioning from the "art" of physical therapy toward the "profession" of physical therapy, with a more recent national emphasis on "autonomous" or "direct access" physical therapist practice. According to the Webster's dictionary, autonomy can be defined as "having the right or power of self-government; undertaken or carried on without outside control; self-contained; existing or capable of existing independently; responding, reacting, or developing independently of the whole." If the view of professional autonomy is in concert with this definition, some may argue that physical therapy could be likened to an art, where practitioners are free to design unique diagnostic and therapeutic regimens for each individual patient, drawing on clinical knowledge and experience, without distractions, regulations, or oversight. Proponents of this type of system believe that practitioners intuitively know the best way to manage individual patients, that the purity of practitioners' motives will insure optimal patient care, and that the personal competency of practitioners will result in quality health care.<sup>7</sup> Unless this was the intended interpretation, we likely chose the wrong term altogether to describe what we should be seeking. In fact, if the perspective of professional autonomy focuses on the attributes of professionalism, an expanded and almost contrary model emerges. In this model, the profession holds a specialized body of knowledge. It is self-regulating, members are free to provide care within the profession's scope of practice, and the expectation is that performance should be consistent with the best scientific evidence available. Members of the group are responsible for the integrity and expansion of the profession's knowledge base and are accountable for their actions. Proponents of this type of system believe that compliance or

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<sup>1</sup> Assistant Professor and Director of Research, US Army-Baylor University Doctoral Program in Physical Therapy, San Antonio, TX.

<sup>2</sup> Assistant Professor, Regis University, Denver, CO.

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conformity to standards of best or evidence-based practice will ensure optimal patient outcome, reduce utilization of resources, and allow practitioners to control and regulate their own health care delivery. Herein lies the “paradox of autonomy”<sup>7</sup>: to become more autonomous as a profession, individual practitioners must become less independent and more accountable to the profession. So, you be the judge. Did we pick the right term?

The profession of physical therapy is not the only health care profession to struggle with the balance between professional and individual autonomy. As discussed by Reinertsen, the medical profession has also been faced with the paradox of autonomy, as well as the impact of their actions on both patient outcomes and health care utilization.<sup>7</sup> Physicians achieved unprecedented autonomy in the 20th century, largely attributed to scientific advances during this period that rapidly improved the effectiveness of medical practice.<sup>7</sup> However, this “honeymoon period” was gradually overshadowed in the late 20th century by increased scrutiny and oversight among third-party payers and growing consumer distrust because of wide variations in the quality of care, differing levels of integrating scientific advances into practice, and the rise in medical errors.<sup>4</sup> Based on this experience, Reinertsen proposed that there are 3 ways to lose your autonomy: (1) create a culture that tolerates mistakes and does not deal effectively with colleagues who fail to fulfill their professional obligations; (2) don’t follow the evidence; and (3) permit unwarranted practice variation.<sup>7</sup> In the spirit of learning from history, and from the lessons learned from other professions that have undergone similar transition periods, we propose that these same principles apply to our profession of physical therapy, representing ways that we will lose, or never gain, legitimate professional autonomy.

With a focus more solely on the first premise about ways to lose autonomy, one may ask “How is this done”? Historically, licensure boards and legal systems have dealt with egregious mistakes performed by physical therapists. However, to optimize the likelihood that the paradigm shift toward Vision 2020 will be realized and that physical therapists achieve a level of professional autonomy similar to that of other medical disciplines, individual members of our profession must ultimately be responsible for policing the profession. Additionally, the members of our profession must ensure that they are continuing to update their knowledge base and use the current best evidence that is applicable to their respective patient populations.

One approach of moving in the direction of policing ourselves is through benchmarking. First, we must determine where we stand in various areas of physical therapist practice, analyze and benchmark our performance, and implement changes or improvements in the process to produce better outcomes of care. With this idea in mind, we pursued assessment of student and practicing physical therapist knowledge in musculoskeletal medicine. As many of you may be aware, Freedman and Bernstein<sup>3</sup> assessed knowledge in basic nonsurgical musculoskeletal medicine among 85 physicians during their first week of their internship following graduation from medical school, using a standardized examination. The mean score was just under 60%, with only 18% of physicians scoring above a level determined by orthopaedic program directors as the minimum threshold necessary to establish competency in musculoskeletal medicine in the primary care setting.<sup>3</sup> Matzkin et al<sup>6</sup> recently demonstrated similar suboptimal levels of knowledge in musculoskeletal medicine among medical students, residents, and virtually all physician specialists except for orthopaedists. Our question was, “How does physical therapists’ knowledge in musculoskeletal medicine compare to that of physicians?” With our rapid progress toward having direct access in all states, and given the frequency of musculoskeletal conditions encountered in physical therapist practice, we thought this was a particularly relevant question.

To answer our question regarding physical therapists’ knowledge relative to physicians, we replicated the Freedman and Bernstein study among both first professional degree physical therapist students nearing graduation and practicing physical therapists. The results, are reported elsewhere in detail.<sup>2</sup> Briefly, 174 physical therapist students from 12 randomly selected educational programs and 182 practicing physical therapists completed the same examination administered by Freedman and Bernstein<sup>3</sup> and Matzkin,<sup>6</sup> assessing knowledge in

managing musculoskeletal conditions. As with most data, the results are mixed. Practicing physical therapists demonstrated higher levels of knowledge in managing musculoskeletal conditions than medical students, physician interns and residents, and all physician specialists except for orthopaedic surgeons. Furthermore, practicing physical therapists who were board certified in orthopaedic or sports physical therapy achieved significantly higher scores and passing rates than their non-board-certified colleagues.<sup>2</sup> Although physical therapy students performed better than all physician groups except orthopaedists, they did not perform as well as we expected. Only 24% achieved the passing score established by Freedman and Bernstein, compared to a 19% passing rate among physician interns<sup>3</sup> and a more favorable 67% pass rate among practicing physical therapists. Interestingly, first professional degree students enrolled in doctoral degree educational programs achieved significantly higher scores than their peers enrolled in master's degree programs, providing at least preliminary evidence for an increased focus on the diagnosis of commonly encountered musculoskeletal conditions and orthopaedic emergencies in the curricula of doctoral level physical therapy programs.

Based on the results of this recent study, how do you answer the question, "Do physical therapists have the requisite knowledge necessary to manage musculoskeletal conditions in a direct access setting?" Furthermore, how can we apply our findings to the concept of creating "a culture that doesn't tolerate mistakes, and one that deals effectively with colleagues who fail to fulfill professional obligations"? Perhaps professional obligations should be extended to our accrediting bodies and professional associations in conjunction with individual clinicians. On one hand, all physical therapists, regardless of board certification, degree status, and experience, performed at least as well as physicians, who are presumed to be competent to provide direct access care for patients with musculoskeletal conditions upon graduation from medical school. If we set our sights on performance as good as that of primary care physicians, then we can rest comfortably and convince ourselves that we're doing fine. On the other hand, are we missing the point if we settle for substandard performance? If we are striving to become the musculoskeletal providers of choice with direct access for patient care, and acknowledge that most physical therapists don't have an array of imaging and lab tests at their immediate disposal to assist in clinical decision making, is the passing rate of our students and practicing clinicians really good enough, or should we strive to be better? Given the emphasis on musculoskeletal conditions in the curricula of physical therapist educational programs, all of us thought that our graduates' performance would have been better. We were unfortunately mistaken. This study exposed the "emperor with no clothes."

So, in the big picture, where do we go from here? It appears that perhaps we are not as well prepared in musculoskeletal medicine as we would like to be. Ultimately, we would like to see information regarding actual outcomes of care for patients treated by our students and recent graduates, but at this time this information may be the best evidence we have regarding student preparation in musculoskeletal diagnostic arena. Based on this, we must face the fact that there is room for improvement and move forward. We propose that there are 3 ways to respond to this information. One option is to "shoot the messenger." Individuals and organizations with a low tolerance for disappointing news will gladly join in the fray. Another option is blissful ignorance, in which we bury our heads under the pillow and hope it goes away. A third option—the only viable path in our opinion—is to take action as accountable practitioners supported by accountable national professional organizations. We should embrace a healthy debate at the forefront of our profession's consciousness regarding how we can do better. For example, we should strive toward outcomes-based evaluation criteria, in which data regarding outcomes of care for patients treated by our students and recent graduates are reported in a standardized manner. We should responsibly engage members of the education community, current clinicians, the Commission on Accreditation of Physical Therapist Education, various health care delivery systems, and other stakeholders, allowing data to inform a meaningful dialogue regarding needed competencies for musculoskeletal direct access care. From a more global perspective, we must take a leadership role in raising the level of musculoskeletal care in the entire health care system. This requires both an inward focus on our own profession and an outward commitment to work with our primary care colleagues. If we pursue this path, we will find solutions that propel us toward rapid

advancement of physical therapist practice and the achievement of Vision 2020 well before 2020. The vast majority of states have approved direct access legislation; therefore, the proverbial train has left the station. We are all responsible for shaping our arrival at the final destination. Stay tuned next month for a discussion on the remaining 2 ways to lose your autonomy (or never get it): (1) don't follow (or teach) the evidence and (2) permit unwarranted practice variation.

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## REFERENCES

1. American Physical Therapy Association House of Delegates. Vision 2020. HOD 06-00-24-35. 2000. Alexandria, VA: American Physical Therapy Association; 2000.
2. Childs JD, Whitman JM, Sizer PS, Pugia ML, Flynn TW, Delitto A. A description of physical therapists' knowledge in managing musculoskeletal conditions. *BMC Musculoskelet Disord*. 2005;6:32.
3. Freedman KB, Bernstein J. The adequacy of medical school education in musculoskeletal medicine. *J Bone Joint Surg Am*. 1998;80:1421-1427.
4. Kohn LT, Corrigan JM, Donaldson MS. *To Err Is Human: Building a Safer Health System*. Washington, DC: Institute of Medicine, National Academy Press; 1999.
5. Massey BF, Jr. Making vision 2020 a reality. *Phys Ther*. 2003;83:1023-1026.
6. Matzkin E, Smith EL, Freccero D, Richardson AB. Adequacy of education in musculoskeletal medicine. *J Bone Joint Surg Am*. 2005;87:310-314.
7. Reinertsen JL. Zen and the art of physician autonomy maintenance. *Ann Intern Med*. 2003;138:992-995.