Autonomy in Physical Therapy: Less Is More

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This issue of the JOSPT is the second of 2 dedicated to the topic of direct access physical therapy. Achieving direct access is an important component of the Vision 2020 statement set forth by the American Physical Therapy Association. This aspect of Vision 2020 is coming to fruition, with the majority of states now permitting direct access to physical therapists. Other related concepts promoted within Vision 2020 are professionalism and autonomy. Vision 2020 promotes the goal that physical therapists will “hold all privileges of autonomous practice,” with autonomous practice defined as “independent, self-determined, professional judgment and action.” Measuring the achievement of direct access is relatively straightforward. We may simply tally the number of states whose practice acts permit such access. Gauging our advance toward the goals of autonomy or professionalism is more difficult. The first step in analyzing our progress is to define our target so that we might be aware of where we are headed and recognize the destination once we arrive.

Autonomy and professionalism are concepts that create a degree of tension and possibility for conflict. Autonomy, as evident from the APTA’s definition, focuses on the individual practitioner, with terms such as independent and self-determined. Professionalism is characterized by a social contract between groups in society and the corporate body of physical therapists. The extent to which the expectations of society are met largely determines the degree of autonomy society will grant that profession. What is it that society expects? Society expects a profession to possess specialized knowledge and to use it altruistically in the service of patients and society. Society further expects a profession to regulate itself, maintain the integrity of its knowledge base, and maintain standards to assure quality.

Professions, such as physical therapy, and individual practitioners lose (or fail to gain) autonomy when they fail to meet society’s expectations of professionalism. As pointed out in the editorial accompanying the first issue of our 2-part series, the experience of physicians provides specific examples of factors that result in a loss of autonomy. In this editorial we will examine 2 particular factors: (1) not following the evidence, and (2) permitting unwarranted practice variation.

Clinical prediction rules have been developed that dramatically aid in the diagnosis of musculoskeletal conditions commonly encountered by physical therapists, such as ankle sprains and cervical radiculopathy. In addition, there are screening tools that can be applied when examining patients with musculoskeletal complaints to rule out serious disorders such as cancer. Are these being routinely employed in physical therapists’ clinics? We do not have good data on these issues; however, we do have data that suggest that physical therapist interventions vary widely when managing musculoskeletal disorders. For example, low back pain is the most common musculoskeletal disorder encountered by physical

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therapists. However, as physical therapist educators, it is commonplace to hear physical therapist students return from a clinical rotation with a statement such as “We didn’t get any training in myofascial release techniques in school, but my clinical instructor used this procedure on almost all patients with acute nonradicular low back pain.” We then ask the student, “Did the therapist do this procedure after attempting procedures, such as thrust and nonthrust spinal manipulation, that have evidence supporting their use, and after the patient failed to achieve a positive outcome?” The answer is all too frequently no. Fortunately, many clinical instructors are realizing that a knowledge gap exists. They readily identify that our physical therapy students are competent in both mobilization/manipulation skills and have knowledge of the current best evidence. We as physical therapist educators must teach and be proficient with current best evidence as the minimal standard of competency. We must provide for our students an environment that fosters the knowledge and skills to stay current throughout their professional career in a rapidly changing health care environment.

Emerging physical therapy procedures that may show promise in the clinic but are not published should be considered techniques that are “kept an eye on” using automated literature search strategies. Emphasis on procedures that lack evidence creates unwarranted noise in the educational system and fosters an attitude that “anything goes” in clinical practice. We must close the chasm between current practice and current best practice.

When you see your cardiologist for potentially life-threatening cardiac symptoms, do you hope that she is a fully autonomous practitioner who prefers to treat the way she learned in medical school 20 years ago? Or would you prefer that at a minimum she provided a standard of care based on the current best evidence that has been shown to decrease mortality? If there is not an acceptable standard of care based on the evidence, then how do we confidently refer our friends and family members, let alone all members of our society, to individual practitioners and be relatively certain that they will get an acceptable standard of care? According to a recent RAND study, Americans—even in the best of circumstances—receive only about 55% of the recommended care for a variety of common conditions. If individual physical therapists cannot provide a consistent evidence-based package of care for the common conditions that they encounter, then we as physical therapy professionals risk losing our autonomy.

The risk of unwarranted practice variation is not only a threat to our professional autonomy but, more importantly, threatens the quality of care we offer to our patients. The Institute of Medicine defines health care quality as “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” It is not surprising that inconsistent care is often associated with inconsistent clinical outcomes. For example, despite strong evidence for pharmacologic therapy and smoking cessation advice in the treatment of acute myocardial infarctions, studies have found the rate of utilization of these evidence-based interventions to vary substantially across the United States. It is not surprising that substantial geographic variation also exists in mortality rates from the condition. Physical therapy care has not received this level of inquiry. But do we have any basis to believe that our practice patterns and subsequent outcomes would look any more consistent? The reasons underlying the lack of standardization around evidence-based care are many, but our tolerance for unwarranted variation and too much individual autonomy will ultimately result in worse outcomes for our patients and greater scrutiny and regulation for our profession. For example, we currently have good evidence on what is the best method of managing acute low back pain, a $90-billion annual problem. Spinal manipulation and exercise are a basic package that should be available to all patients. We have always been a profession of motion and exercise and should be providing this as the standard of care. We are at the tipping point. If we choose to follow the evidence and demand the same of our professional colleagues in low back pain management, as well as in management of other common musculoskeletal conditions, then we will look back on this era as the point at which our profession gained true autonomy. Although the Vision 2020 calls for greater individual autonomy for physical therapists, our profession may actually benefit from less.
REFERENCES