Allied health professions and the non-physician-referred practice of physiotherapy

In 1977 and 1978 the Canadian Medical Association (CMA) expressed sufficient concern with the training of allied health personnel that the General Council proposed the setting up of a joint subcommittee of the Council on Medical Education and the Council on Medical Services to study the role of the medical profession in the education and guidance of allied health groups.[1,2]

Many allied health groups (e.g., diagnostic and therapeutic radiologic technicians, nuclear medicine technologists, respiratory technologists, medical laboratory technologists and cytotechnologists) are closely associated with the medical profession, the schools that provided the education and their own professional organizations in a combined accreditation evaluation of the educational facilities and programs and their product. Good liaison between the medical and allied health groups results, and quality standards are maintained.

However, two important allied health groups — physiotherapists and occupational therapists — prefer not to enter an accreditation program with related medical specialists through the CMA. These therapists are valued members of the health care team whose drive for independence from medicine and the medical model has concerned their closest allies in the medical specialties for years.

The medical profession is deeply and reasonably concerned about health care that is not intimately tied into an optimally scientific program — one that is guided with the best and widest knowledge, and is coordinated from the highest level. Medicine's mandate in Canadian society is the medical health care of Canadians, and we are obliged to ensure its quality whenever we can. We are therefore concerned about any of our therapists who do not wish to work closely with us to produce health professionals who are optimally trained and disciplined to satisfy the patient's needs.

The political and, to a large extent, educational leaders of occupational therapists and physiotherapists are seeking an autonomy that is taking their people further away from the field of medicine. The leaders are intelligent, well meaning people who seek higher educational standards, a broadening of the scope of their professions and self-determination. However, two of their methods deserve evaluation and constructive criticism.

First, schools of occupational therapy and physiotherapy are taking a nonmedical direction. At one Canadian university at least, this has progressed to the establishment of a faculty of rehabilitation medicine, whose dean is a speech pathologist. Despite the name there is no connection with the faculty of medicine, essentially no medical input into the curriculum and no medical evaluation of the graduating personnel. The implications of this are immense and therefore will not be discussed in this article.

Second, at their annual meeting in June 1978 the members of the Canadian Physiotherapy Association (CPA) voted to alter their code of ethics to allow physiotherapists to directly assess and treat "clients" without medical referral, following the "acquisition of adequate and appropriate information concerning such clients" (*Medical Post,* July 18, 1978, page 21).

The CPA plans to petition the provincial governments for regulation changes to permit nonmedically referred treatment by physiotherapists. Quebec already has such legislation. I leave it to my French-speaking confrères to explain why they have turned to therapists trained by the collèges d'enseignement général et professionnel, which are not recognized by the CPA, to treat their patients. Recently the Australian Physiotherapy Association has also endorsed nonmedical referral (personal communication: J.M. Henderson, deputy secretary general, Australian Medical Association, 1978).

What does nonmedical referral mean? Who will be affected? Despite the heart-warming assurances of many experienced and less militant physiotherapists that the written "intent" of physiotherapists to obtain adequate and appropriate information concerning the client will be adhered to, this change in the code of ethics clearly allows any willing therapist to treat a person who asks for help. With official permission to give treatment how many physiotherapists will assume a role beyond their competence? I hope these will not be many, but assuredly there will be some and in ever-increasing numbers. The CPA cannot police the quality of its therapists when its code of ethics permits totally autonomous activity.

In this day of multidisciplinary medicine, when every medical doctor recognizes his or her limitations and seeks help and guidance from physicians who are especially trained in the needs of the patient, we cannot honestly support patient management by allied health groups who do not have the endorsement in their treatments and evaluations of the more highly trained medical professionals. The team approach is lost, the medical model of health care delivery with the physician coordinating and supervising the team is bypassed, and the patient cannot be optimally served. Thus, it is the patient who will be affected (*Western Medical News,* September 1978, page 4).

What will be the response of members of the medical profession? Let us remember that each allied health profession is a product of physicians who recognize the need for special services for their patients, who then create and train the allied health professional to supply those services. We must continue to ensure the best medical input into their efforts. This does not deny the allied health pro-

fession's contribution to their own methods, their aspirations for recognition of their expertise or their desire to grow. Their aspirations and knowledge, our knowledge and the patient's needs must meld. Proper care can never be accomplished in the isolation that can be anticipated with the rejection of the medical model.

Such statements as these will be regarded as paternalistic, despite no such intention on the part of the medical profession. Each profession, including the medical profession, must assume appropriate autonomy in the ultimate interest of the patient.

Physicians must evaluate their present contribution to the problem of inappropriate autonomy of allied health professions by looking at three aspects: education of the allied health groups; supervision as the team captain; and knowledge in the area of movement disorders, and especially the disease states managed by physical methods.

Physicians must once again play an important role in the education of physiotherapists and occupational therapists. Curricula must be appropriate to the needs of the patient, not just to the aspirations of the therapist. These curricula must not be determined by physiotherapists and occupational therapists alone, or by physicians alone, but by mutual input and planning. The medical contribution cannot be made by part-time physicians who are too busy seeing patients. The guidance must come from physicians trained in physical methods of treatment and interested in teaching.

Physicians must supervise and coordinate programs being conducted for their patients. They must consult frequently with the treatment team, for it is rarely excusable for a physician to send a patient to a physiotherapist or occupational therapist because he or she does not know what else to do. This invites therapists to take over and is followed all too frequently by prolonged inappropriate treatment.

Supervision in physical medicine and rehabilitation service departments of hospitals is a role that must be assigned to medical doctors. These hospital services are currently based on multidisciplinary programs and require overall medical supervision. Each therapist would be appropriately autonomous but still only a team member. Occupational therapy, prosthetics, orthotics and nursing are all important parts of the field of physical medicine and they ally closely with medical social services and psychology. Physiotherapy is only part of the physical medicine multidisciplinary service. Medical personnel specially trained in physical methods must supervise the teams.

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.

Physiotherapists trained in institutions autonomous from the input of curricula planning by medical doctors and medical product evaluation can also only lead to a decrease in the quality of patient care.

A physician who uses physiotherapists and other physical treatment professionals must ensure that he or she is adequately knowledgeable to lead the team or must solicit the help of other physicians who can diagnose and manage the patient more appropriately.

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