

## PHYSIOTHERAPY IN PRIMARY HEALTH CARE: ARE WE READY?

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### **Abstract:**

*Given the growing interest of the Nigerian physiotherapists in primary care, it is important to understand the general concept of this health care delivery system and the responsibilities associated with being a primary care provider. Physicians are historically trained to shoulder the responsibilities of a primary care provider. Other professionals are also redesigning their curriculum in order to be able to provide primary care within other health care professions such as physiotherapy and nursing due to large number of patients the physicians have to attend to. The evolving primary care practice in physiotherapy is a direct function of the first-contact / direct-access privilege in physiotherapy. This paper describes the concept of primary care and the role of physiotherapists within this practice environment.*

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**Keywords:** Physiotherapy, Primary Care, direct access, triage, medical screening, imaging, pharmacology

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### **Background**

Primary Care (PC) is defined as the coordinated, comprehensive, and personal care provided on a first-contact and continuous basis.<sup>1</sup> PC incorporates primary and secondary prevention of chronic disease states, wellness, personal support, education, and addresses the personal health care needs of patients within the

context of family and community.<sup>1,2</sup> Based on PC definition, one may argue that without the ability to provide care on a first-contact and continuous basis, there can be no PC system of health care delivery.

The evolving PC practice in physiotherapy is a direct function of the first-contact / direct-access privilege in physiotherapy and a product of the need for a quicker access to the needed health care services especially in the rural communities. The clinician involved in the PC setting holds enormous responsibilities to which he is accountable. He determines whether the management of the presenting condition is within his scope of practice or whether referral to other providers is necessary. Primary care providers (PCP) are largely physicians in general practice and in pediatrics. The delays in accessing the needed health care services due to paucity of physicians especially in the rural areas called for more PCP other than the physicians. Non-physician PCP includes physician assistants and nurse practitioners in the developed countries. Among other factors, direct-access practice privilege in physiotherapy paved way for physiotherapists (PTs) in PC in many other countries. Given the growing interest of the Nigerian physiotherapists in primary care, it is important to understand the general concept of this health care delivery system and the responsibilities associated with being a primary care provider.

PC concept for PTs implies that the therapist is

the first point-of-entrance into the health care system. In a broader scope of PC delivery system, the physiotherapist (PT) could also see patients by referral in the same way the physician sees a patient by referral from a PT within the system. Because of the quick-access philosophy of primary health care delivery, the involved PT is required to have the ability to see the patient on a first contact basis. In 1988, laws were promulgated with the establishment of the Medical Rehabilitation Therapists Board to guide the practice of physiotherapy in Nigeria. Unfortunately, the stipulations that came with the establishment of the board severely limit how PTs practice in Nigeria. By the law that guides physiotherapy practice, without a doctor's order, PTs are not allowed to see any patient even if the patient were an excellent candidate for physiotherapy. This is without any doubt, characteristic of a profession that has no autonomy. Is this what we want as professionals? Definitely not! In my opinion, things have to change and we have to start our journey towards achieving autonomy of practice as a matter of urgency.

The rest of this paper will describe the role of physiotherapists within PC practice environment. Autonomy and direct-access as they relate to primary care will be analyzed. The current physiotherapy primary care models will be highlighted with special reference to the United States. The additional skills and training required of physiotherapists to function effectively and safely as a primary care provider will be elaborated. Barriers to achieving primary care practice in physiotherapy with reference to Nigeria will be discussed and, the solutions for overcoming the barriers will be offered.

### **ROLE OF PHYSIOTHERAPISTS IN PRIMARY CARE**

Ryan and colleagues<sup>2</sup> identified two primary functions of PTs in PC environment as examination and triage. The goals of this patient encounter include 1) Implementing a physiotherapy plan of care when appropriate, 2) deciding whether a referral to a physiotherapist certified clinical specialist is warranted, 3) deciding whether certain

imaging studies are needed to enhance the diagnostic process and, 4) deciding if a physician consultation is indicated. In addition, the therapist is responsible as a patient advocate to see that the patient's neuromusculoskeletal and other health care needs are identified and prioritized, and a plan of care established.<sup>1</sup>

There is enough evidence to support the fact that PTs are the experts in the examination, evaluation, diagnosis and conservative treatment of neuromusculoskeletal problems.<sup>5</sup>

<sup>6</sup> In this capacity, PTs can play an important and direct role in a PC setting to help meet the numerous needs of patients with neuromusculoskeletal problems. A physician and an associate professor of medicine wrote in his comment about the role of PTs in PC thus: "academic instruction and training in the evaluation of musculoskeletal problems are very limited for most PC physicians."<sup>2</sup> Because of this limited training in the evaluation of neuromusculoskeletal injuries, many physicians often rely on the physiotherapist to perform a more detailed examination of a patient's injury and symptoms and participate in the diagnostic process.

It is therefore not surprising that a study conducted in Britain in 1995 comparing outcomes and patient satisfaction between orthopedic PTs and orthopedic surgeons concluded thus: "an appropriately trained physiotherapist is as effective as staff grade surgeons in managing orthopedic out-patients unlikely to benefit from surgical intervention."<sup>3</sup> I will like to remind us that a surgeon is never a PC provider. It is therefore advantageous to have a professional in a PC setting who is effective in the management of neuromusculoskeletal problems. Who better fill this position other than the physiotherapist? Now let us look at the impact of autonomy and direct-access on primary care for PTs in Nigeria.

### **AUTONOMY, DIRECT-ACCESS AND PRIMARY CARE**

Autonomy is defined by the Webster

dictionary<sup>3</sup> as “self governing,” “not controlled by others” which means, and of course, the freedom to make independent decisions. Therefore autonomous practice is independent, self-determined professional judgments and action for which the individual involved is responsible. The independence that comes with autonomous physiotherapy practice is not meant to isolate the PTs, rather, it should enable collaborative relationships with other health care providers in an atmosphere of respect for one another.

Freidson,<sup>4</sup> a referred sociologist of the professions describes two types of professional autonomy: technical autonomy and socioeconomic autonomy. Technical autonomy is “the right to use discretion and judgment in the performance of work.” It has been said that society gives the professions wide, but not total independence in terms of technical autonomy. The society expects a profession to possess specialized knowledge and skills that are to be used altruistically in the service of the society. PTs in some societies have earned the respect of the society by demonstration of specialized skills and by being advocates for their profession. In return, the society granted the PTs certain degree of autonomy that paved way for direct-access privilege among other privileges for the therapists in these societies. Direct-access enables the patient to come to the physiotherapist directly without first seeing a physician or other health care professionals. The biggest part of autonomy that relates to PC as described earlier in Goodman and Snyder's<sup>1</sup> definition is our ability to see patient without referral. Unfortunately, in Nigeria by law, we are restricted to function only in a referral-based capacity. What else can this indicate other than an absolute lack of autonomy of practice. If we cannot see patient on a first-contact basis, the whole idea of PC practice pattern we are seeking in Nigeria will be defeated.

Socioeconomic autonomy on the other hand has to do with the ability of the worker to

ascertain and allocate the economic resources needed to complete his or her work.<sup>4</sup> There is the need to seize our technical autonomy significantly before we can logically address socioeconomic autonomy. As a result, socioeconomic autonomy will not be elaborated in this paper. The next segment will discuss various PC models for physical therapists with special reference to the United States.

### **PRIMARY CARE PHYSIOTHERAPY MODELS**

The evolution of the PC physiotherapy practice in the United States (US) is so unique and discussing the various models of PC for PTs in the country is worth focusing on in this section.

#### **US Army Model**

The US Army Model utilizes the triage system where the entry point personnel record vital signs and area of complaint. The patient with neuromusculoskeletal problems is then channeled to the physiotherapist for consultation without first seeing a physician. The PT has the responsibility to ensure that the patient who directly accessed him or her by triage system is appropriate for PT and that, there were no serious pathology mimicking or accompanying the patient's neuromusculoskeletal complaint. Other health care providers in this clinical environment may also refer patients to the PT in the traditional manner. In the latter situation, the referring physician's responsibility to provide appropriate diagnosis for the referred patient does not abrogate the therapist's responsibility to ensure that the neuromusculoskeletal diagnosis is adequate and that the referral is appropriate.

The US armies PTs are trained and credentialed to serve in the capacity of a typical PC providers and as a result, they have expanded privileges beyond the standard physiotherapy scope of practice. Following their professional education, US army PTs are required to have a 6-month training period

prior to being credentialed as a non-physician health care provider in the military. Additional training may include courses in diagnostic imaging, pharmacology, medical screening and supervised clinical mentoring. The expanded privileges of the US army PTs include the ability to refer patients to radiology for appropriate imaging studies, restrict patients to their living quarters for up to 72 hours and, restrict work and training for up to 30 days. In some medical facilities US army PTs are also allowed to prescribe limited non-steroidal anti-inflammatory medications and analgesics.<sup>7</sup>

### **Kaiser Permanente Model**

Kaiser Permanente Northern California (KPNC) is the largest non-military health maintenance organization in the US. KPNC developed a model of physical therapy practice that is integrated into the PC environment. This organization recognized the diagnostic skills and treatment expertise of PTs in managing patients with neuromusculoskeletal conditions. Instead of having this group of patients see a physician or a nurse practitioner initially, Kaiser utilizes screening algorithms that enable the patient to see the needed provider on a first contact basis when appropriate. Within this system, a patient may access physical therapy services by direct-access through screening algorithms mentioned earlier. Physical therapy services may also be accessed by physician referral or by joint consultation with both the physician and the physical therapist.

KPNC developed competencies for the PC therapists and established a policy that those functioning in this role should have a minimum of 4-6 years of outpatient orthopedic experience. They are also required to demonstrate excellent team communication skills. In addition, therapists are prepared via educational courses on differential diagnosis of neuromusculoskeletal versus non-neuromusculoskeletal conditions and acute neuromusculoskeletal injuries of the peripheral joints. Training is also conducted on radiologic review of plain films and magnetic resonance images, laboratory values

relevant to PC practices, and pharmacology. Competencies in these required areas are determined by written examination. The most valuable of the elements of the physiotherapist's preparation for PC is clinical mentoring program in which experienced PTs facilitates the acquisition of the necessary skills.

### **Department of Veterans Affairs Model**

The Veteran Affairs (VA) health care system exists primarily to deliver health care to the living America's veterans (military retirees). Given the relatively advanced aged of veteran patients, they frequently have multiple medical problems such as heart disease, hypertension, arthritis and diabetes. In addition to their medical needs, there are often social circumstances that complicate their care. As a result, an interdisciplinary, interdependent health care team is utilized in the VA management approach. Four management domains were identified with each provider having responsibility for specific domain.<sup>2</sup> The domains are pharmaceutical, dietary, psychosocial and, mobility. In most VA medical centers, a team consisting of a physician, dietician, social worker, pharmacist, nurse practitioner and sometimes a psychologist delivers PC.<sup>2, 8</sup> Based on this composition, it is obvious that a typical PC team in the VA system lacks an expert in the mobility / exercise domain. In the VA system, exercise prescription is synonymous to drug prescription, in that dosage is usually dependent on the individual patients taken into account the patient's situation. The realization that proper attention was not given to mobility / exercise domain by the PC team in the VA system led to the development of a team that includes PTs.

In the VA system, PTs in PC are required to have knowledge of diagnostic imaging, screening for non-neuromusculoskeletal pathology, ECG monitoring, pharmacology, and pathophysiology of chronic diseases.<sup>8</sup> A 4-month internship program was developed to prepare PTs for PC responsibilities. Successful coverage of the identified knowledge areas is mandatory prior to working in the PC clinics. In this system, a patient with

neuromusculoskeletal system may access physical therapy services by triage through the emergency departments or the hospital's telephone system. Patients may also gain access to physical therapy through established PC clinics.

### **CLINICAL COMPETENCIES OF A PRIMARY CARE PHYSIOTHERAPIST**

From the PC models described above, it is obvious that PC responsibilities for PTs demands further training beyond the basic or what we might call the entry-level PT training. The required further training will be elaborated later in this paper. Seen in PC settings is a diverse population of patients with equally diverse and complex health issues. Therefore, skills in differential diagnosis, medical screening, interdisciplinary communication, community health and education are required. Knowledge of imaging is also required to know what kind of imaging study to request from another provider and where allowed, to order when needed. Understanding drug interactions in the body is also essential and needed for PTs in PC setting. Having said this, the competencies required of a PC physiotherapist depend largely on the type of practice setting and the extent of privileges given within the setting to the therapist.

### **BARRIERS TO ACHIEVING PRIMARY CARE PRACTICE IN PHYSIOTHERAPY**

In my opinion, four factors might affect the integration of physiotherapy into PC in Nigeria. First, our educational programs do not prepare the student PTs as a provider in the PC setting. This of course is not unique to Nigeria. In the US, PTs whose primary training lacked educational components needed to be a safe and effective PC provider do attend structured post-professional programs to make up for their deficiencies. This brings us to the second factor, which is the lack of post-professional, competency-based educational programs to prepare PTs for PC challenges. Appropriate post professional program will not only be competency-based, but structured in a way that it could effectively prepare PTs for an expanded role in the healthcare system. Thirdly, we have

minimal to no autonomy of practice and this is in fact, the genesis of the fourth factor, which is, dependent practice pattern. Dependent practice pattern implies the inability to see patients without the doctor's approval. Simply put, we have no direct-access or first-contact practice privilege in Nigeria. The laws regulating the practice of our profession in Nigeria totally position us at the mercy of the referring providers, which in many cases are the medical doctors. This practice pattern defeats the purpose of PC for PTs in Nigeria. This has to change!

### **THE SOLUTIONS**

There is the need to be systematic in solving this problem. We cannot afford to adopt the so called "fire brigade approach." We need to set up a committee or a task force to deal with the barrier issues mentioned earlier. Gaining direct access or first contact is the most important issue here. To gain direct-access means we have to change the law. Changing the law requires evidence of the need to make the change. It may be easy to come up with the evidence in light of quick access to healthcare need especially in the rural communities. If the evidence is accepted, then the professional qualification to act in the capacity of a PC provider becomes a relevant question. Therefore, we need to solve the problems of adequate training before we make the move to change the law. The rest of this paper will deal with, in my opinion, what we need to do to provide adequate training to prepare us for PC challenges at both the undergraduate and the post-professional levels.

#### **Undergraduate training augmentation**

There is the need to revamp the physiotherapy curriculum to reflect relevant items of learning and skills acquisition that would enhance clinical performance as a PC provider. The following is, but not by all means, the exhaustive list of the learning items to be added to the current PT curriculum that may be helpful in preparing our students for PC responsibilities.

1) Medical screening training is essential to enhance prompt identification of non-

neuromusculoskeletal problems mimicking or associated with neuromusculoskeletal problems.

2) Orthopedic differential diagnosis training is necessary to be able to pinpoint the root cause of neuromusculoskeletal problems. Evidence-based orthopedic management of the spine and extremities should also be taught including basic manual therapy.

3) Diagnostic imaging education should be provided to assist the students in decision making regarding the type of imaging study to recommend during the diagnostic process if needed.

4) Medications are being administered to a large majority of patients seen by PTs. We all know that medication can alter clinical presentation and it may also change the course of physiotherapy intervention. Therefore, the students must have a working knowledge of pharmacology.

5) Communication skills should be taught to enhance efficient professional communication with patients and other health care providers.

6) Restructuring the mandatory internship program and making it PC residency programs might be a good way to reinforce the augmented curriculum.

#### **Post-professional training strategies**

For some of us who have already graduated from physiotherapy schools, conducting a critical evaluation of our current clinical skills in relation to the required skills needed to function safely and effectively as a PC provider is essential. It may be helpful for the NSP and the licensing board to develop a standard self-assessment tool to assist the PTs to determine individual training deficiency. Upon recognition of the deficiency, necessary steps may then be taken to address the areas of weakness. Relevant continuing education courses may be attended to make up for the deficiencies and if this is well planned, it may lead to an advanced certification in PC. Individual therapist may be encouraged to pursue further clinical education if incentives are given to do so. These incentives may include but not limited to increased professional compensation in terms of salary and promotions. Professionally, we may have to

sacrifice by getting advanced clinical education without any hope of incentives for a while. We can ask for incentives once the society has seen what we are capable of doing. By so doing, we would have been able to help our patients more competently with newly acquired knowledge and the society would have recognized our unique skills and knowledge. We need the recognition of the society to gain autonomy and we will all benefit from this as a profession.

#### **Lobbying**

Having addressed the issue of training, the next step is lobbying to change the laws that regulate our practice. Setting up a well funded lobbying committee that would get the legislators to promulgate laws that will favour our services. Let us all use our connections with the politicians to make this work. It is very important to convince the lawmakers of how the current laws that regulate our profession affect timely access of the needed health care services by common Nigerians. Are we going to need money to get this legislative action going? Yes of course! I guarantee you all that every PT both in practice and in training will give financial support to any action that they know will offer them autonomy of practice that will set them free professionally.

#### **CONCLUSION:**

Autonomy of practice that paves way for freedom to make independent decisions is essential to gain direct-access privilege. With direct-access and aggressive public relations campaign, PTs recognition as a PC provider will become a reality. Involvement of PTs in primary health care setting will not only expose more people to our clinical skills and knowledge, but also, an enhanced public awareness of our professional expertise will be an added advantage. Our professional image will improve when people starts perceiving us as providers of services that can only be offered by competent and autonomous professionals. Based on the information presented in this paper, it is pertinent at this point to ask the big question; are we ready to become PC providers? The road towards any kind of change is always rough and many challenges

and barriers are to be expected. However, autonomy of practice and expansion of our clinical skills and knowledge in a very aggressive and yet, calculated manner will move us in a positive direction towards becoming primary care providers in Nigeria.

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