

TO: Annie Schiefer, Project Manager  
Health Professions Regulatory Advisory Council  
55 St. Clair Avenue West  
Suite 806, Box 18  
Toronto, Ontario, Canada M4V 2Y7

From : Michael Poling, M.Sc.(Kin), M.Sc.(PT)  
Physiotherapist, Ergonomist, Kinesiologist  
Faculty, Northern Ontario School of Medicine

RE: HPRAC Scope of Practice review for Physiotherapists

Thank you for the opportunity to respond to the scope of practice review.

Having read the submission from the Ontario College of Family Physicians, I can see that clarification is definitely needed for physicians regarding the education and CURRENT scope of practice of physiotherapists, especially private practice physiotherapists much less the scope of practice that we should have.

As a faculty member of a Canadian medical school, I can tell you that even new family residents are surprised with the level of education, which far exceeds family physicians in several areas (musculoskeletal being only one), that a physiotherapist exhibits. I have family residents following me on rounds all the time, and the diagnostic accuracy of physiotherapists is always one piece of feedback that is always given. One example is the diagnostic accuracy on predicting lumbar MRI findings. Currently, an experienced physiotherapist is able to predict the findings on MRI in a lumbar spine between 81 and 93% of the time. Orthopaedic surgeons are able to do this between 77 and 91% of the time. Family physicians, 50-65% of the time. Based on that, physiotherapists would be able to communicate the diagnosis and refer for an MRI much more appropriately than a family physician.

Many of the family physicians I work with refer to me with a request of "assess, diagnose and treat as you need" and tell the patient "this physiotherapist will find the problem and let you know what it is." This frees the family physician to see the next patient, who may be much more in need of their services.

Physiotherapists could easily reduce the workload of physicians and are primary care practitioners, meaning we have the training needed to know when something is in need of another health care professional. We have been doing this for years. It is not new. Many of us were the researchers and developers behind many of the "Red Flags" that physicians use to screen patients.

I see our increased scope of practice as being able to have patients assessed by the appropriate individual. If a patient is coming in with heart problems, or with internal medicine problems, we ARE INDEED trained to refer such a condition to the family physician. We ARE trained to be able to assess a DVT from a Gastrocnemius tear (calf

tear). In fact, I have caught several DVT's which were missed by the family physician or even an ER physician. Why? Because they were overburdened with cases which could have been appropriately handled by another health care profession. Physicians have been the gatekeepers to the remainder of the health care system for a long time, and I can understand why they wish that to remain. It seems logical to have a single person directing traffic.

But this assumes you have enough "traffic cops" or that the "traffic cop" can catch everything, work long hours, knows everything and can handle the stress. If not, you may need to rely on another system.

I think all of my referring physicians, visiting residents and students would agree that the above is not true for anyone.

True interprofessional collaboration is about sharing the power, information, control and care. Sharing the power of referral for tests and specialist appointments, the information each of us has within our specific training (which is differing training, not superior), the control of who a patient sees for each specific condition and the care that is appropriate to, and provided to the patient .

We do not have that in Ontario. Other provinces and countries do and have shown that it works.

The argument has been made in 2 submissions that PT's might order MRI's unnecessarily. Good point, if it were based in fact. However, ALL studies done on the subject (references to a few below) have showed that we order FEWER tests...mainly because we don't need them as often as we are better trained in our clinical evaluation techniques.

Heck, even the curriculum I currently teach could improve. Using Bates as a guide to clinical musculoskeletal exam is like using aspirin to treat chronic pain...it might be ok, but there is better stuff out there.

I respectfully suggest that you seriously consider that PT's could provide a very good answer to a struggling healthcare system in Ontario. It's struggling for a reason. We've been doing the same thing over and over and it is not working. Our population is aging and requiring MORE care, not less. Let us help, but let us do it properly, with the abilities we have to our fullest potential. We haven't let our patients down yet, and we won't in the future.

Journal of Epidemiology and Community Health, Vol 53, 643-650, A randomised controlled trial. Shifting boundaries of doctors and physiotherapists in orthopaedic outpatient departments, **G Daker-White, AJ Carr, I Harvey, G Woolhead, G Bannister, I Nelson and M Kammerling** , Department of Social Medicine, University of Bristol.

<http://www.efort.org/cdrom2008/P837.pdf>

**Effect of an extended scope physiotherapy service on patient satisfaction and the outcome of soft tissue injuries in an adult emergency department, *Emergency Medicine Journal* 2006;23:384-387**