



SAFETY OF DIRECT ACCESS TO PHYSICAL THERAPY

1. Direct Access is safe. There is no relationship between direct consumer access and malpractice claims nor is there an increase in reports of physical therapist malpractice following a change to direct consumer access. Comparable evidence has been found in Sweden and in the UK. Additionally, the major insurance carriers for physical therapist liability insurance have the same premiums for therapists in direct consumer access and non-direct consumer access states. These insurance carriers affirm that there is no increase in malpractice claims in those states with direct consumer access.
 - 2005 Moore JH, McMillan D, Rosenthal M, Weishaar M. Risk determination for patients with direct access to physical therapy in military health care facilities. *J Orthop Sports Phys Ther*; 35(10):674-678.
 - 2006 Lane M. Vice President of Professional Standards and Assessment of Federation of State Boards of Physical Therapy (FSBPT) letter to the American Physical Therapy Association (APTA).
 - 2007 Sandstrom R. Malpractice by physical therapists: descriptive analysis of reports in the National Practitioner Data Bank public use data file, 1991-2004. *J Allied Health*; 36:201-208.
 - 2013 Green M, Shoemaker MJ, Basore T, Polso A. Physical therapist professional autonomy, medical malpractice, and adverse professional license action: results from a twenty-year review of the National Practitioner Data Bank. *Physical Therapy Journal of Policy, Administration, and Leadership*, 2013;13(3);J1-J10.
 - 2012 Ludvigsson ML, Enthoven P. Evaluation of physiotherapists as primary assessors of patients with musculoskeletal disorders seeking primary health care. *Physiotherapy*. 2012;98:131-137.
 - 2015 Mintken PE, Pascoe SC, Barsch AK, Cleland JA. Direct Access to Physical Therapy Services Is Safe in a University Student Health Center Setting. *J Allied Health*. 2015 Fall;44(3):164-8.
 - 2017 Bishop A, Ogollah RO, Jowett S, et al. Stems pilot trial: A pilot cluster randomised controlled trial to investigate the addition of patient direct access to physiotherapy to usual GP-led primary care for adults with musculoskeletal pain. *BMJ Open*. 2017;7(3).
 - 2019 Bornhöft L, Larsson MEH, Nordeman L, Eggertsen R, Thorn J. Health effects of direct triaging to physiotherapists in primary care for patients with musculoskeletal disorders: A pragmatic randomized controlled trial. *Therapeutic Advances in Musculoskeletal Disease*. 2019;11:1-13.
 - 2013 Loughran M., President Healthcare Division of Healthcare Providers Service Organization (HPSO) letter to the American Physical Therapy Association (APTA) January 24, 2018.
2. All licensed physical therapists have graduated from a physical therapy program accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE). CAPTE is the only accrediting body for physical therapist education and is approved by the U.S. Department of Education. Physical Therapist education and training prepares the graduate for direct consumer access and includes an emphasis on screening for diseases and conditions outside the scope of practice of a physical therapist. Physical therapists must meet the same educational standards whether they will practice in a direct consumer access state or not. Physical therapists must pass the National Physical Therapist Exam (NPTE)

for licensure regardless of whether that state has direct consumer access or not. It is inconceivable how a physical therapist can graduate from an accredited program, pass the NPTE, and practice safely under direct consumer access in 48 other states, the District of Columbia, and the United States Military, but cross the border into Michigan and suddenly become a danger to patients.

3. Physical therapists are trained to determine a physical therapy diagnosis (not a medical diagnosis). They are trained to screen for and identify health conditions that lie outside the PT scope of practice and require referral to a physician. This is what we currently do because, despite the physician prescription requirement, physical therapists are held liable for ensuring that we are practicing within our scope of practice and that the referral from the physician is appropriate. Eliminating the prescription requirement changes the accessibility of physical therapy services for the consumer – it would not change our scope of practice. Furthermore, the majority of prescriptions for physical therapy are non-specific (e.g. “shoulder pain”) and require the physical therapist to determine a physical therapy diagnosis. Research shows that more specific prescriptions containing a specific diagnosis from a physician do not result in a better clinical outcome.

2008 Brooks G, Dripchak S, Venbeveren P, Allaben S. Is prescriptive or open referral related to physical therapy outcomes in patients with lumbar spine-related problems? *J Orthop Phys Ther* 2008; 39:109-115.

NOTE: This study was conducted in Michigan

2005 Davenport TE, Watts HG, Kulig K, Resnik C. Current status and correlates of physicians’ referral diagnoses for physical therapy. *J Orthopaedic Sports Phys Ther.* 2005;35(9):572-579.

1994 Clawson AL, Domholdt E. Content of physician referrals to physical therapists at clinical education sites in Indiana. *Phys Ther.* 1994;74:356-360.

4. Childs et al (2005) found that both physical therapists and student physical therapist performed better on a standardized examination regarding knowledge of management of musculoskeletal conditions than medical students, physician interns, residents, and a variety of physician specialty groups except orthopedists. The authors concluded that physical therapists can provide safe and effective care in outpatient musculoskeletal practice settings.

2005 Childs JD, Whitman JM, Sizer PS, et al. A description of physical therapists’ knowledge in managing musculoskeletal conditions. *BMC Musculoskel Disord.* 2005;6:32.

5. Boissonnault et al (2010) reported on 81 patients seen under direct access in a non-profit, hospital-based outpatient department. Retrospective physician review of physical therapist management decisions determined that these decisions were appropriate 100% of the time, which included making referrals for additional imaging studies, medical consultation, and medication for pain management.

2010 Boissonnault WG, Badke MB, Powers JM. Pursuit and implementation of hospital-based outpatient direct access to physical therapy services: an administrative case report. *Phys Ther.* 2010;90:100-109.

6. Physical therapists have 3 years of training in musculoskeletal evaluation and management. Non-orthopedic physicians have considerably less training. DiCaprio et al noted that: "Nearly half of American medical schools allow their students to graduate without having had any formal training-clinical or basic science-in musculoskeletal medicine. Fewer than half of the medical schools offer a distinct course in the preclinical years, and four of five do not require a clinical rotation." Of the 25 schools that did require a clinical rotation only 4 schools required the clinical to last 4 weeks, all others were as short as 2 weeks. Skelley et al found that less than 20% of medical students at a sample institution passed a musculoskeletal competency exam.

2003 DiCaprio et al. Curricular Requirements for Musculoskeletal Medicine in American Medical Schools. *J Bone Joint Surg Am.* 2003; 85: 565-567.

2012 Skelley NW, Tanaka MJ, Skelley LM, LaPorte DM. Musculoskeletal education: an institutional survey. *J Bone Joint Surg AM.* 2012; 94: e146(1-7).

7. No evidence exists to show that accessing treatment from a physical therapist results in misdiagnosis and harm. Quite the opposite is true. Over 35 published case reports demonstrate physical therapists' ability to screen for medical disease that required further physician evaluation or management. Many of these cases were patients referred from physicians with incorrect diagnoses.

1997 Robert G, Stevens A. Should general practitioners refer patients directly to physical therapists? *British Journal of General Practice.* 1997;47:314-318.

1999 Gray JC. Diagnosis of intermittent vascular claudication in a patient with a diagnosis of sciatica. *Phys Ther.* 1999;79:582-590.

1998 Greenwood MJ, Erhard RE, Jones DL. Differential diagnosis of the hip vs. lumbar spine: five case reports. *J Orthop Sports Phys Ther.* 1998;27(4):308-315.

2003 Cleland JA, Venzke JW. Dermatomyositis: evolution of a diagnosis. *Phys Ther.* 2003;83(10): 932-945.

2005 Weishaar MD, McMillian DJ, Moore JH. Identification and management of 2 femoral shaft stress injuries. *J Orthop Sports Phys Ther.* 2005;35(10):665-673.

2005 Thein-Nissenbaum J, Boissonnault WG. Differential diagnosis of spondylolysis in a patient with chronic low back pain. *J Orthop Sports Phys Ther.* 2005;35(5):319-326.

2005 Sasaki M. Cervical cord compression secondary to ossification of the posterior longitudinal ligament. *J Orthop Sports Phys Ther.* 2005;35(11):722-729.

2005 Ross MD, Bayer E. Cancer as a cause of low back pain in a patient seen in a direct access physical therapy setting. *J Orthop Sports Phys Ther.* 2005;35(10):651-658.

2005 Garber MB. Diagnostic imaging and differential diagnosis in 2 case reports. *J Orthop Sports Phys Ther.* 2005;35(11):745-754.

2005 Asavasopon S, Jankoski J, Godges JJ. Clinical diagnosis of vertebrobasilar insufficiency: resident's case problem. *J Orthop Sports Phys Ther.* 2005;35(10):645-650.

2005 Browder DA, Erhard RE. Decision making for a painful hip: a case requiring referral. *J Orthop Sports Phys Ther.*

2005;35(11):738-744.

- 2005 Johnson MP, Abrams SL. Historical perspectives of autonomy within the medical profession: considerations for 21st century physical therapy practice. *J Orthop Sports Phys Ther.* 2005;35(10):628-636.
- 2005 Sasaki M. Cervical cord compression secondary to ossification of the posterior longitudinal ligament. *J Orthop Sports Phys Ther.* 2005;35:722-729.
- 2005 Mamula CJ, Erhard RE, Piva SR. Cervical radiculopathy or parsonage-turner syndrome: differential diagnosis of a patient with neck and upper extremity symptoms. *J Orthop Sports Phys Ther.* 2005;35(10):659-664.
- 2005 Stowell T, Cioffredi W, Greiner A, Cleland J. Abdominal differential diagnosis in a patient referred to a physical therapy clinic for low back pain. *J Orthop Sports Phys Ther.* 2005;35(11):755-764.
- 2006 Thomas M, Kershaw JM. Errors in the Clinical Decision Making in a Patient with Persistent Hip Pain: A Case Study. *Orthopaedic Physical Therapy Practice.* 2006;18(2):8-11.
- 2007 Troyer MR. Differential diagnosis of endometriosis in a young adult woman with nonspecific low back pain. *Phys Ther.* 2007;87:801-810.
- 2007 Few CD, Davenport TE, Watts HG. Hypothesis-oriented Algorithm for Symptom-based Diagnosis by Physical Therapists: Description and Case Series. *Orthopaedic Physical Therapy Practice.* 2007;19(1):72-79.
- 2008 Mechelli F, Preboski Z, Boissonnault W. Differential diagnosis of a patient referred to physical therapy with low back pain: abdominal aortic aneurysm. *J Orthop Sports Phys Ther.* 2008;38(9):551-557.
- 2009 VanWyeWR. Patient screening by a physical therapist for nonmusculoskeletal hip pain. *Phys Ther.* 2009;89:248-256.
- 2009 Crowell MS, Gill NW. Medical screening and evacuation: cauda equine syndrome in a combat zone. *J Orthop Sports Phys Ther.* 2009;39:541-549.
- 2009 Mintken PE, Boyles RE. Tarsometatarsal joint injury in a patient seen in a direct-access physical therapy setting. *J Orthop Sports Phys Ther.* 2009;39(1):28.
- 2009 Neilson B, Boyles, RE. Osteochondral defect of the medial femoral condyle. *J Orthop Sports Phys Ther.* 2009;39(6):490.
- 2012 Boissonnault WG, Ross MD. Physical therapists referring patients to physicians: a review of case reports and series. *Orthop Sports Phys Ther.* 2012 May;42(5):446-54. doi: 10.2519/jospt.2012.3890.
- 2013 Heick JD, Boissonnault WG, King PM. Physical therapist recognition of signs and symptoms of infection after shoulder reconstruction: a patient case report. *Physiother Theory Pract.* 2013 Feb;29(2):166-73. doi: 10.3109/09593985.2012.714444.
- 2016 Mourad F, Giovannico G, Maselli F, Bonetti F, Fernández de la Peñas C, Dunning J. Basilar impression presenting as intermittent mechanical neck pain: a rare case report. *BMC Musculoskelet Disord.* 2016;17(7):1-5.
- 2017 Fuchs RK, Bayliss AJ, Warden SJ. Hemangioma in the anterior thigh with corresponding periosteal bone reaction. *J Orthop Sports Phys Ther.* 2017;47(3):218.
- 2017 Stanley LE, Berkoff DJ. Benign peripheral nerve sheath tumor in a distance runner. *J Orthop Sports Phys Ther.* 2017;47(2):125.



- 2019 Collinsworth KM, Bush L, Goss D. Primary synovial osteochondromatosis discovered after ankle sprain. *J Orthop Sports Phys Ther.* 2019;49(4):284.
- 2019 Benedetti M, Spinosa M, Mechelli F. Plica Syndrome and bilateral osteochondritis dissecans. *J Orthop Sports Phys Ther.* 2019;49(10):762.
- 2020 Plummer J. Chronic nonbacterial osteomyelitis. *J Orthop Sports Phys Ther.* 2020;50(10):585.
- 2020 Houser JD, Carow SD. Diagnosis of Ewing's Sarcoma after a fall. *J Orthop Sports Phys Ther.* 2020;50(5):276.
- 2020 Mourad F, Maselli F, Cataldi F, Pennella D, Fernández-De-Las Peñas C, Dunning J. Hip bone marrow edema presenting as low back pain: a case report. *Physiother Theory Pract.* 2020;36(1):249-257.
- 2021 Maselli F, Storari L, Barbari V, et al. Can Haglund's Syndrome be misdiagnosed as low back pain? Findings from a case report in physical therapy direct access. *Healthcare.* 2021;9:508.
- 2021 Mourad F, Cataldi F, Patuzzo A, et al. Craniopharyngioma in a young woman with symptoms presenting as mechanical neck pain associated with cervicogenic headache: a case report. *Physiother Theory Pract.* 2021;37(4):549-558.