Approved: 14th October, 2016

Due for review: October 2019

Scope of practice

The purpose of this position statement is to provide support for physiotherapists in Australia when they seek to describe their scope of practice.

We are stating our position with respect to the scope of physiotherapy practice in order to support physiotherapists in the provision of safe, high quality, timely, cost-effective, sustainable physiotherapy in the Australian community.

Practice is more than the provision of direct clinical care

Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a practitioner in their regulated health profession. For the purposes of this position statement, practice is not restricted to the provision of direct clinical care. It also includes:

- using professional knowledge in a direct non-clinical relationship with patients or clients working in:
  - management
  - administration
  - education
  - research
  - advisory, regulatory or policy development roles, and
- working in any other roles that have an impact on safe, effective delivery of health services in the health profession.[1]

Scope at profession level and individual level

The APA defines the physiotherapy profession's scope of practice as:

> 'The full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within the profession are educated, competent, and authorised to perform.'[2]

Individual physiotherapists enact their scope of practice within the broader 'scope of practice' of the profession as a whole.[3]

There are several important factors to consider when you're describing the scope of physiotherapy practice in Australia:

- depth and breadth of **competence**

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[1] Based on the definition of 'practice' in the Physiotherapy Board of Australia Code of conduct for registered health practitioners. http://www.physiotherapyboard.gov.au/Codes-Guidelines.aspx

[2] Adapted from Nursing and Midwifery Board of Australia (NMBA). A national framework for the development of decision-making tools for nursing and midwifery practice.

[3] White D Oelke ND Besner J et al. Nursing scope of practice – descriptions and challenges. Nursing Leadership 2008;21(1): 44-57, at p.49.

- the nature and effectiveness of **safeguards** in the settings in which physiotherapy is undertaken
- the law, including the **legislative and regulatory environment**.

Our approach is to accentuate the potential reaches of physiotherapy at profession and individual levels, whilst not unduly restricting the profession and its members.

The aim of our approach is to be pliable, and descriptive rather than prescriptive, reflecting the changing context of the profession and the healthcare industry. Our approach aims to provide a model that adjusts alongside the continuous development of the profession's collective scope of practice.[4] It is our intention to describe the scope of practice for physiotherapy in a way that ensures that there are safeguards in place for both pioneering physiotherapists and the broader collective of physiotherapists, as well as for the community and the health system. To achieve this, we advocate a collective and individual view of physiotherapy.

We encourage an informed, self-auditing culture in the profession, because the confidence of our patients and the community is essential. Moreover, to preserve and enhance this confidence we emphasise that physiotherapists are guided by their own moral and ethical compass, rather than simply following a rule because it is a rule.[5] Although the term 'regulation' is often synonymous with government legislation and regulation, we appreciate that self-regulation by individual physiotherapists and peer-regulation within the profession is also important.

The heart of physiotherapy

The scope of physiotherapy practice surrounds a heart: the essence of physiotherapy. In our model, we refer to this as the 'core'. The core is the special knowledge and skills in a widely recognised body of learning derived from research, education and training which physiotherapists possess and the public accept that they possess.

> *'(Physiotherapy is) services to individuals and populations to develop, maintain and restore maximum movement and functional ability throughout the lifespan. This includes providing services in circumstances where movement and function are threatened by ageing, injury, pain, diseases, disorders, conditions or environmental factors. Functional movement is central to what it means to be healthy. (Physiotherapy) is concerned with identifying and maximizing quality of life and movement potential within the spheres of promotion, prevention, treatment/intervention, habilitation and rehabilitation. This encompasses physical, psychological, emotional, and social wellbeing'*.[6]

Physiotherapy is concerned with maximising quality of life

Physiotherapists have extensive knowledge of physiology and anatomy. We have recognised skills in diagnosis, treatments and screening involving musculoskeletal conditions[7] and neurological practice,[8] and,

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[4] See APA Scope of Practice background document on dynamism of scope of practice (forthcoming).
[5] Smith E Reeves R. Papering Over the Cracks?-Rules, Regulation and Real Trust. Work Foundation; 2006.
[6] World Confederation for Physical Therapy. [Internet]. London; 2016 [cited 2016, July]. Available from: http://www.wcpt.org/policy/ps-descriptionPT
[7] Harding P, Prescott J, Block L, O'Flynn AM, Burge AT. Patient experience of expanded-scope-of-practice musculoskeletal physiotherapy in the emergency department: a qualitative study. Australian Health Review. 2015 Jul 6;39(3):283-9.
[8] Edwards S. Neurological physiotherapy: a problem-solving approach. Elsevier Health Sciences; 2002.

more broadly, we are the profession of choice in diagnosis, intervention and prevention of impairments and restrictions related to movement, function and health.[9]

Physiotherapy is embedded in the rehabilitation and community health system through well-established channels of communication. There is a significant body of high level evidence (both randomised controlled trials and systematic reviews) for disciplines of physiotherapy.[10]

Physiotherapists are primary contact professionals with excellent communication skills who are well placed to manage patients according to their needs and to understand the patient experience in the health system.[11] These skills mean physiotherapists working at the frontier of traditional scope of practice could provide much needed efficiencies in the Australian health system and relieve pressure on other health professionals.[12 13]

Evidence from available literature suggests that progressing scope of practice for physiotherapists will contribute to meeting the ever-increasing demands on our health system. However, further research and economic evaluations of cost-effectiveness, sustainability and patient outcomes are needed.[14 15 16]

Our scope of practice model

Safe practice is paramount in physiotherapy

Trust is a core, defining characteristic that gives the physiotherapist-client and physiotherapy-community relationship meaning, importance and substance. Trust is essential to effective therapeutic encounters.[17]

We appreciate that to maintain our patients' confidence, physiotherapy needs to be safe and of consistently high quality. However, a physiotherapist's competence is, by itself, an insufficient safeguard against harm. Therefore, we take a systemic approach to safe practice, where human fallibility and errors are better

[9] American Physical Therapy Association. Vision 2020. [Internet]. Virginia: American Physical Therapy Association; 2016 [cited 2016, June]. Available from: http://www.apta.org/Vision2020/

[10] Moseley AM, Herbert RD, Sherrington C, Maher CG. Evidence for physiotherapy practice: a survey of the Physiotherapy Evidence Database (PEDro). Australian Journal of Physiotherapy. 2002 Dec 31;48(1):43-9.

[11] As illustrated in the public health system: Taylor NF, Norman E, Roddy L, Tang C, Pagram A, Hearn K. Primary contact physiotherapy in emergency departments can reduce length of stay for patients with peripheral musculoskeletal injuries compared with secondary contact physiotherapy: a prospective non-randomised controlled trial. Physiotherapy. 2011 Jun 30;97(2):107-14.

[12] Morris J, Vine K, Grimmer K. Evaluation of performance quality of an advanced scope physiotherapy role in a hospital emergency department. Patient related outcome measures. 2015;6:191.

[13] Ruston SA. Extended scope practitioners and clinical specialists: A place in rural health? Australian journal of rural health. 2008 Jun 1;16(3):120-3.

[14] Desmeules F, Roy JS, MacDermid JC, Champagne F, Hinse O, Woodhouse LJ. Advanced practice physiotherapy in patients with musculoskeletal disorders: a systematic review. BMC musculoskeletal disorders. 2012 Jun 21;13(1):1.

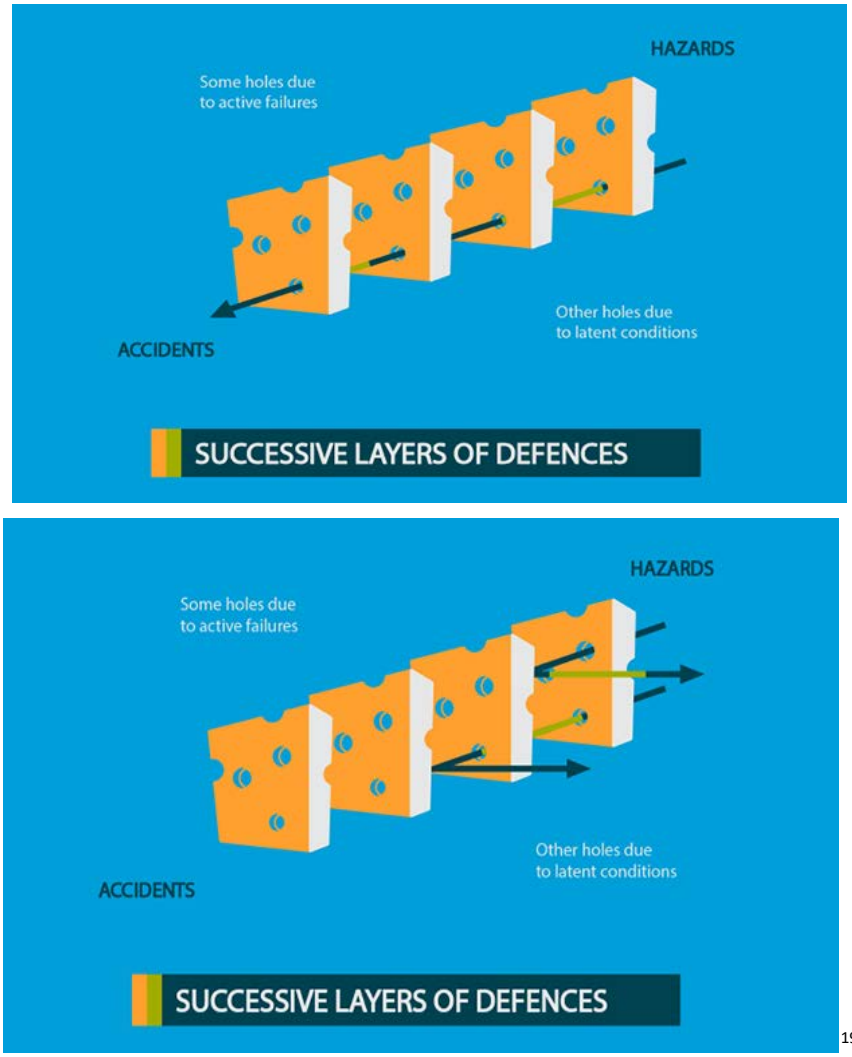
[15] Saxon RL, Gray MA, Oprescu FI. Extended roles for allied health professionals: an updated systematic review of the evidence. J Multidiscip Healthc. 2014 Oct 13;7:479-88.

[16] Standfield L, Comans T, Raymer M, O'Leary S, Moretto N, Scuffham P. The Efficiency of Increasing the Capacity of Physiotherapy Screening Clinics or Traditional Medical Services to Address Unmet Demand in Orthopaedic Outpatients: A Practical Application of Discrete Event Simulation with Dynamic Queuing. Applied health economics and health policy. 2016 Apr 26:1-3.

[17] Hall MA Dugan E Zheng B et al. Trust in physicians and medical institutions – What is it, can it be measured and does it matter? Milbank Quarterly 2001;79(4):613-39.

understood and accounted for, and the causes of harm are seen to lie both with the system and the individual.

The overall aim of this approach is to increase reliability by safeguarding against the 'perfect' conditions for harm to occur. This approach to preventing harm has been widely cited and described as the 'Swiss cheese model'. In this model, the holes in the system may be perfectly aligned for a trajectory of harm or they can be closed through a series of safeguards.[18]



[19]

This means that our position on scope of practice is informed both by understanding competence, but also by understanding safeguards.

[18] Reason J. Human error: models and management. BMJ. 2000 Mar 18;320:768-70.

[19] Duke University School of Medicine. [Internet]. North Carolina; 2016 [cited 2016, September]. Available from: http://patientsafetyed.duhs.duke.edu/module_e/swiss_cheese.html

The frontiers of physiotherapy

Inherent in the notion of 'scope', and particularly the 'extent' of scope, are opportunity and possibility, and also barriers, boundaries or constraints.

Although the literature uses different terms to describe these boundaries in different ways,[20] [21] there is substantial commonality in the essential nature and type of the boundaries.

In order to acknowledge the dual aspects of possibility and constraint, we describe the edge of scope as 'frontiers'.

The three critical frontiers that are central to the scope of physiotherapy practice:

- professional competence and capability
- settings and their safeguards
- the law (including legislation and regulation).

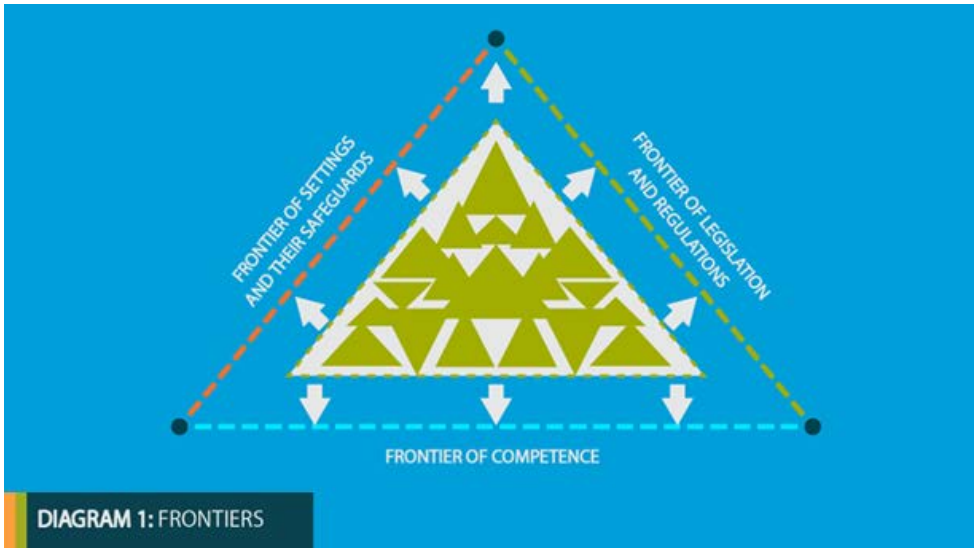


DIAGRAM 1: FRONTIERS

[20] Niezen MG Mathijssen JJ. Reframing professional boundaries in healthcare: A systematic review of facilitators and barriers to task reallocation from the domain of medicine to the nursing domain. Health Policy 2014;117(2):151-69.

[21] White D Oelke ND Besner J et al. op cit.

Competence

The extent of the knowledge base of the profession (i.e. professional competence and capability) is one of the most commonly discussed frontiers of physiotherapy. [22] [23]

Developing competency standards and standardised training are crucial for external recognition of, and confidence in, a physiotherapist's capacity to carry out tasks.[24] [25] National accreditation requirements for universities and other training venues define the range and level of competence required to enter the profession of physiotherapy—to be competent in the core of physiotherapy.[26] This ensures that the community can have confidence in physiotherapy, not just 'my physiotherapist'.

However, diligent and conscious self-regulation of competence are also central to our position on scope of practice. This means that scope is determined, in part, by consistent self-reflection by physiotherapists on their competence to enact the activities within their scope of practice. The APA's position is that peers play a central role in both supporting and monitoring the competence of their colleagues in the profession.

This means that physiotherapists need to be diligent in continuing their professional education throughout their professional lives and that they need to have recently practised in any field in which they want to work as a physiotherapist. For those who haven't recently practised in the relevant field, they need to undertake professional development to the extent needed to meet their professional obligations before they return to practice or make a substantial change to their chosen scope of practice.

Competence includes the levels of education and training required to work consistently and safely from the core of practice through to the frontiers of physiotherapy practice.

Clinical and health services research is a critical foundation of the profession. It is central to making progress in the range of the profession's competencies as well as extending the profession's frontier of competence.

Another critical foundation is the role of physiotherapy managers who often play a crucial role in ensuring effective on-the-job competence development. Mentors and champions in the areas of advanced scope are also central to the frontier of competence as we may be developing skills not previously taught in physiotherapy curricula but which are based on core knowledge of physiotherapists who have progressed in their scope before us.

We also appreciate the need for formalised, widely recognised training to develop expertise in and add credibility to advanced scope practice roles. This has been raised as a key concern, particularly in relation to clinical governance.[27] Such training complements informal education, training and enhancement of competence that occurs on a daily basis for physiotherapists across our profession.

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[22] White D Oelke ND Besner J et al. op cit.

[23] Skinner EH Haines KJ Hayes K et al. Future of specialised roles in allied health practice – who is responsible? Australian Health Review 2015;39:255-9.

[24] Morris J, Grimmer K, Gilmore L, et al. Principles to guide sustainable implementation of extended-scope-of-practice physiotherapy workforce redesign initiatives in Australia: stakeholder perspectives, barriers, supports, and incentives. Journal of multidisciplinary healthcare. 2014;7:249.

[25] Morris JH, Grimmer K. Non-medical prescribing by physiotherapists: Issues reported in the current evidence. Manual therapy. 2014 Feb 28;19(1):82-6.

[26] See: https://physiocouncil.com.au/media/1020/physiotherapy-board-physiotherapy-practice-thresholds-in-australia-and-aotearoa-new-zealand-6.pdf

[27] Skinner Haines Hayes et al, op cit. p.256.

One challenge for the profession is to ensure consistency in the application of formal requirements for advanced professional competence and capability, while also not undermining the value of informal learning.

Settings and their safeguards

When discussing clinical settings and work environments, this includes the requirements of the health service in which a physiotherapist works such as:

- safe practice procedures
- duty requirements of the position
- access to appropriate technology (such as electronic patient records and information systems) to make informed and effective treatment decisions, and
- follow-up systems to evaluate and monitor treatment outcomes.[28]

We recognise the central importance of system safeguards and defences against harm and appreciate that the well-designed safeguards in settings where physiotherapy is practised create boundaries for scope of practice. In addition to any one individual safeguard, we support organisational approaches to safeguarding, such as clinical governance, which are used to protect the safety of patients and physiotherapists. These approaches create parameters for the scope of physiotherapy practice. An organisation may, for example, limit or expand the scope of practice of an individual through a job description and/or policy and procedure, such as credentialing.[29]

Principles that influence and underpin the APA's notion of safeguard development are that it is:

- **inclusive** – a collaborative process in which all stakeholders are considered, valued, informed and engaged
- **accountable** – a process of taking responsibility for activities and creating safe environments[30]
- **proportional** – it targets the prevention of the most serious harm
- **just** – it facilitates a culture that is even-handed, predictable, consistent and clearly defined
- **expert** – it has the capability to operate efficiently and effectively. It also collects, analyses and adopts data and evidence
- **dynamic** – the components are planned, have the capacity to evolve and have the ability to respond to new information and changing circumstances. [31]

Professional development and clinical and health services research can facilitate changes at the frontiers of physiotherapy. This can occur through innovation that creates new, effective safeguards against human error. Advances in clinical settings interact with legislation and regulation. Opportunities developed through innovation can prompt legislative change and allow the scope of practice to progress.

Legislation and regulation

In addition to individual and collective professional self-regulation, Australian physiotherapists practice in an environment which has important legislation and government regulation. In line with models of 'modern

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[28] Health Workforce Australia. Health Professionals Prescribing Pathway (HPPP) Project- Final Report. 2013

[29] For a discussion of credentialing, see: Nissen L. Pharmacist prescribing – What are the next steps? A, J Health-Syst Pharm 2011;68:2357-61.

[30] Grimmer, *et al* summarise the literature and issues: Grimmer K, Morris J, Kim S et al. Physiotherapy Practice: Opportunities for International Collaboration on Workforce Reforms, Policy and Research. Physiotherapy Research International. 2016 Jan 1.

[31] Krpan S. Compliance and enforcement review- A review of EPA Victoria's approach. EPA Victoria, 2011.

regulation', it is our view that the principles that underpin our notion of safeguard development in settings need to underpin effective legislation and regulation.

One core element of this framework is the Health Practitioner Regulation National Law (the National Law).[32] The National Law establishes a National Registration and Accreditation Scheme (NRAS) for the regulation of health practitioners, as well as students undertaking programs of study that provide a qualification for registration in a health profession or undertaking clinical training in a health profession.

The National Law also places restrictions on a small number of acts. The one relevant to physiotherapy is spinal manipulation.[33]

The National Law provides for the establishment of the Physiotherapy Board of Australia (PhysioBA) and the Australian Health Practitioner Regulation Agency (AHPRA).

The PhysioBA does the following:

- regulates registered physiotherapists
- registers physiotherapists and physiotherapy students
- sets the standards that physiotherapists must meet
- manages notifications (complaints) about the health, conduct or performance of physiotherapists.

AHPRA works in partnership with PhysioBA to implement the NRAS, under the National Law, as it applies in each state and territory.

All physiotherapists must adhere to the relevant legislation and regulations, codes and guidelines within the NRAS. This includes the Physiotherapy Code of Conduct which states that practitioners have a responsibility to recognise and work within the limits of their competence and scope of practice.[34] It also includes meeting the Physiotherapy Continuing Professional Development Registration Standard[35] and the Registration standard: Recency of practice.[36]

The Physiotherapy Code of Conduct embodies the principles of the National Law, purposefully not defining scope of practice in order to facilitate workforce flexibility, rather than creating boundaries.

The legislative and regulatory framework includes a wide range of laws. So although physiotherapists need to be aware of and comply with the standards, guidelines and policies of the PhysioBA, they also need to understand and remain within other relevant legislation and case law.

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[32] https://www.ahpra.gov.au/About-AHPRA/What-We-Do/Legislation.aspx

[33] Section 123
A person must not perform manipulation of the cervical spine unless the person—
(a) is registered in an appropriate health profession; or
(b) is a student who performs manipulation of the cervical spine in the course of activities undertaken as part of—
(i) an approved program of study in an appropriate health profession; or
(ii) clinical training in an appropriate health profession; or
(c) is a person, or a member of a class of persons, prescribed under a regulation as being authorised to perform manipulation of the cervical spine.

[34] Physiotherapy Board of Australia. Code of conduct for registered health practitioners. http://www.physiotherapyboard.gov.au/Codes-Guidelines.aspx (Accessed 1 October 2016)

[35] http://www.physiotherapyboard.gov.au/Registration-Standards.aspx

[36] http://www.physiotherapyboard.gov.au/Registration-Standards.aspx

We value the four cornerstones of regulation

There are four cornerstones of regulation in our scope of practice:

- the individual physiotherapist
- the profession
- government
- the market

It is our position that it is effective to emphasise and enhance the moral compass and ethical obligations that underpin and bind professional individuals and groups when describing the scope of practice of either an individual physiotherapist or the profession's collective scope of practice.

We value the way that an individual physiotherapist can be guided by the sense of the laws governing their profession, rather than the letter of the law. In our view it is important that wherever possible, trust is grounded in a realistic view that the person or institution in question will do the right thing because it is the right thing, not because of a rule.

In some circumstances, over-regulation can have the effect of disenfranchising an individual practitioner, thereby eroding their relationship with the governing body.[37]

However, we recognise that self, peer and market regulation (for example, the role of consumer choice) can fail and that individuals, the profession and the community all deserve and require appropriate legislation and regulation to protect them.

Thus we also recognise and value regulation by government. It can serve to enhance trust **within** the physiotherapy profession and **of** the physiotherapy profession.

Together these four things intersect to give us the four cornerstones of regulation of our scope of practice: the individual physiotherapist, the profession, government and the market.

The overlapping mosaic that is the profession's collective scope of practice

The combination of extrinsic drivers and opportunities (such as population health needs, technologies and funding systems) together with intrinsic drivers and capabilities of physiotherapists (such as interest in older adults or those who wish to explore professional boundaries such as 'pursuit of the new') create a circumstance in which the profession is characterised by overlapping individual scope of practice (overlapping because they all contain the 'core').

[37] Smith E Reeves R. Papering Over the Cracks?-Rules, Regulation and Real Trust. Work Foundation; 2006.

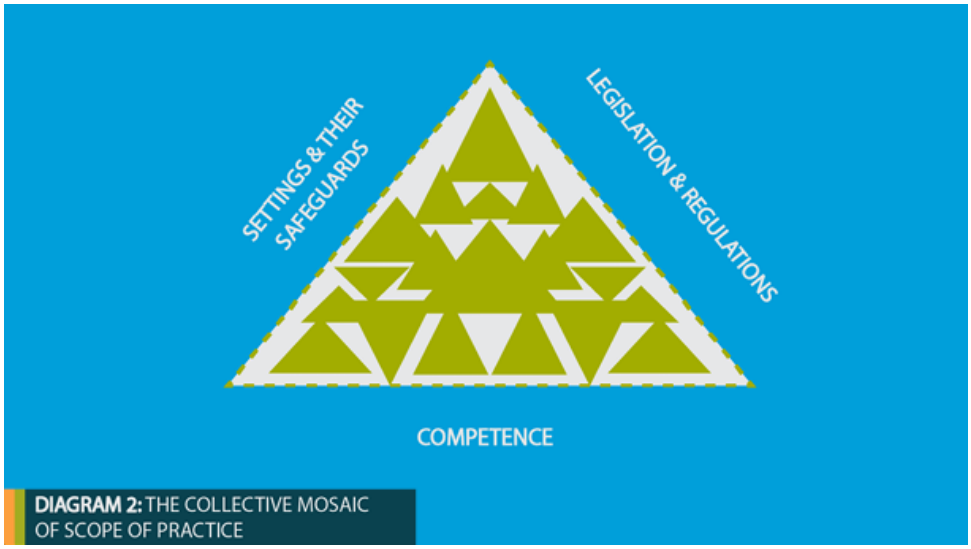

DIAGRAM 2: THE COLLECTIVE MOSAIC OF SCOPE OF PRACTICE

The image shows the collective mosaic of scope of practice, where each triangle represents an individual physiotherapist working to the top of their capabilities. Aspects of the scope of practice of individuals and groups who are pioneers create the advanced 'edge' of the profession.

Shared scope of practice across professions

Some functions within the scope of practice of physiotherapy are shared with other professions, individuals and groups.[38]

Given existing and potential shortages of clinical staff and the need to optimise the roles of all professionals,[39] it is important to design and redesign roles to achieve an optimal staff mix.

We support 'diversification'—the identification of a novel approach to practice that has previously not been owned by a particular disciplinary group, resulting in the expansion of the role for that discipline.[40]

However, we are concerned that role ambiguity may be a serious and costly phenomenon because it contributes to tension in the workplace and potentially results in underutilisation of the workforce.[41] As a result, we appreciate the need for role clarity.

We are also concerned about the risk of 'de-professionalisation'—the loss of the unique qualities of our profession (and others). This includes the loss of profession-specific knowledge and skills; the loss of public

[38] Adapted from: Nursing and Midwifery Board of Australia [Internet]. A national framework for the development of decision-making tools for nursing and midwifery practice. [cited 2016, July] Available from: http://www.thesupplycenter.com/2009/business/practice_scope_summary.pdf

[39] White Oelke Besner op cit.

[40] Nancarrow SA, Borthwick AM. Dynamic professional boundaries in the healthcare workforce. Sociology of health & illness. 2005 Nov 1;27(7):897-919.

[41] Duffield C Pelletier D Donoghue J. Role overlap between clinical nurse specialists and nurse managers. Journal of Nursing Administration 1994;24(10):54-63.

belief in the profession, including its service ethos; the loss of expectations of work autonomy and the loss of an authoritative role with clients.[42]

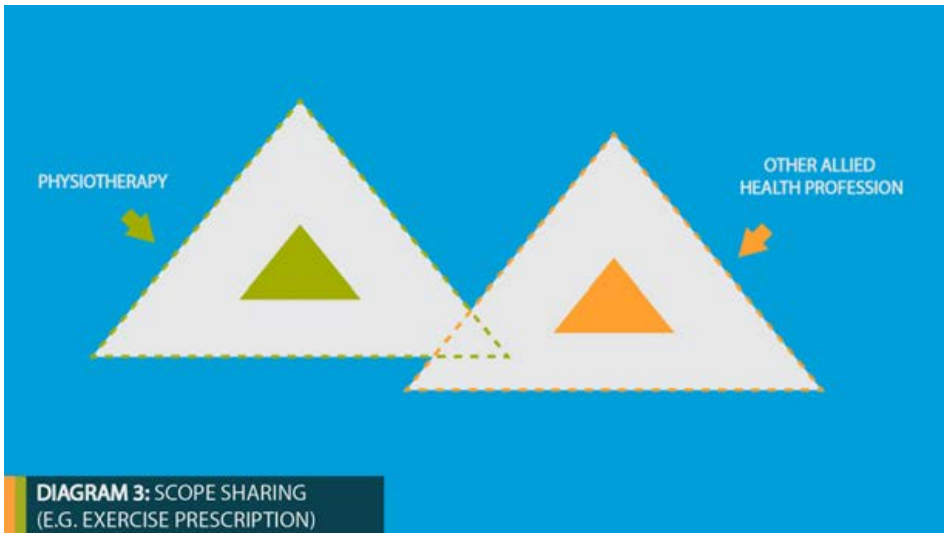

DIAGRAM 3: SCOPE SHARING (E.G. EXERCISE PRESCRIPTION)

Advanced scope of practice

We define advanced scope of practice as roles, functions, responsibilities, activities and decision-making capacities that:

- are recognised as **within** the scope of physiotherapy practice, and
- require distinctly increased clinical skills in physiotherapy reasoning, knowledge and experience, and
- are usually practised by a leading subgroup of the profession, and
- are recognised as being expert by members of the profession, and
- incorporate evidence-based innovations arising within physiotherapy, often arising from structured research, and
- may have, through custom and practice, been performed by other professions. [43]

As a result, advanced scope of practice usually requires additional training, significant professional experience and competency development.

Extended scope of practice

There has been variability in the use of terminology with respect to extended scope of practice.[44]

Extended scope is seen to include expertise beyond the currently recognised scope of practice.[45]

We define extended scope of practice as roles, functions, responsibilities, activities and decision-making capacities that:

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[42] Nancarrow SA, Borthwick AM. op cit.
[43] S.A.R.R.A.H. [Internet]. ACT; 2016 [cited 2016, July]. Available from: https://sarrah.org.au/book/export/html/435
[44] McPherson K, Kersten P, George S, Lattimer V, Breton A, Ellis B, Kaur D, Frampton G. A systematic review of evidence about extended roles for allied health professionals. Journal of health services research & policy. 2006 Oct 1;11(4):240-7.
[45] S.A.R.R.A.H. op cit.

- are **outside** the currently recognised scope of practice because they require change to legislation and/or regulation; and
- require additional training, competency development and significant professional experience; and
- require some method of credentialing following the required training, competency development and professional experience.

As a result, we do not use the term 'extended scope' for aspects of current physiotherapy practice, but rather for desirable and anticipated roles, functions, responsibilities, activities and decision-making capacities that are being explored by the profession. Often this occurs within research trials.

As pioneering research and practice prompt legislative and regulatory change, the result is that *extended* scope becomes *advanced* scope of practice.

Progressing our scope of practice at profession level

Our position on scope of practice incorporates four mechanisms for progressing our scope of practice at a profession-wide level:[46]

- **specialisation** –an increasing level of expertise in a specific disciplinary area by a subgroup of the profession
- **diversification** – identifying a novel approach to practice that has not previously been 'owned' by a particular disciplinary group, resulting in the expansion of the role for that discipline
- **horizontal substitution** – providers with a similar level of training and expertise, but from different disciplinary backgrounds, undertake roles that are normally the domain of another discipline
- **vertical substitution** – the delegation or adoption of tasks across disciplinary boundaries where the levels of training or expertise (and generally power and autonomy) are not equivalent between workers. For instance, the delegation of tasks by physiotherapists to allied health workers.

There are barriers and facilitators in the implementation of new and innovative scope of practice and these are discussed further in the APA background document on scope of practice.

Progressing our scope of practice at practitioner level

The literature on barriers and facilitators in implementing innovative scope of practice explores the roles of knowledge and capabilities, professional boundaries, organisational boundaries, organisational environment, and institutional environment. These issues are also encompassed in our approach.

Individual physiotherapists enact their scope of practice within the broader 'scope of practice' of the profession as a whole. The scope of practice of individual physiotherapists can be described through the same model, where settings and their safeguards, legislation and regulations, and competence intersect with one another.

We use the model of a career trajectory to illustrate the way that a practitioner's scope of practice may shift.

[46] Nancarrow SA, Borthwick AM. op cit.

Graduate

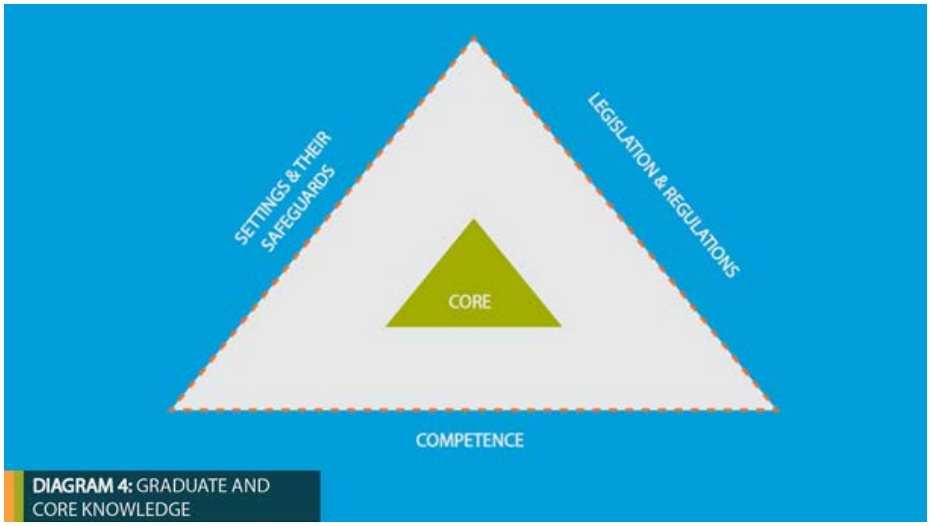

DIAGRAM 4: GRADUATE AND CORE KNOWLEDGE

Graduate physiotherapists all finish their tertiary training with a similar core competence. The scope of their practice is constrained by legislation and regulations (as is the case for their colleagues in the profession) and by the safeguards in the particular setting in which they work. With experience, graduate physiotherapists start moving towards the boundaries of scope in different directions.

Proficient or inexperienced

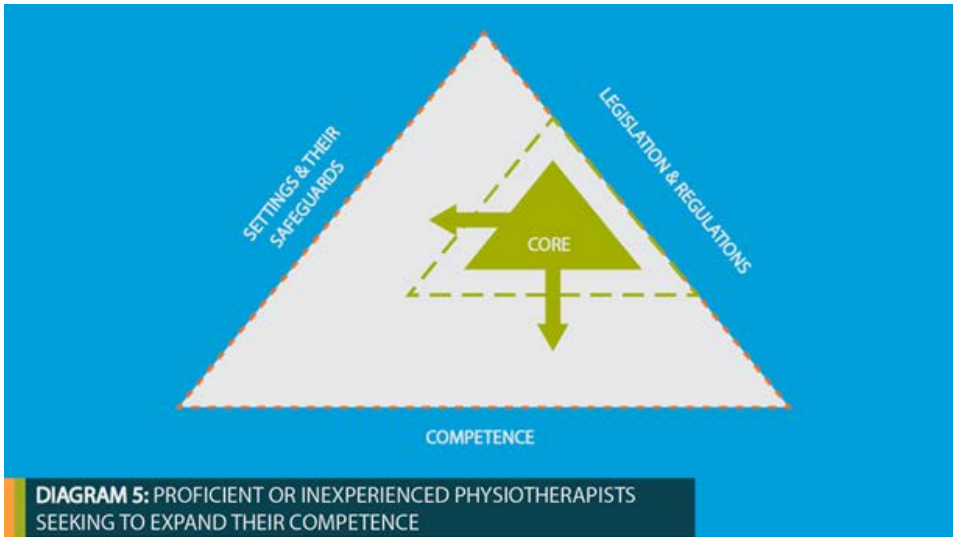

DIAGRAM 5: PROFICIENT OR INEXPERIENCED PHYSIOTHERAPISTS SEEKING TO EXPAND THEIR COMPETENCE

A proficient or inexperienced physiotherapist is bound by legislation and regulation in essentially the same way as more experienced physiotherapists. Their competence broadens with education and experience. As this development occurs, often the scope of their practice is also allowed to broaden by a change in the safeguards in the setting (such as a change in their role). An example of this is a physiotherapist with a couple of years' experience who begins to specialise in paediatric care and takes on a broader role at their hospital (such as working in an outpatient assessment clinic without direct supervision).

Experienced practitioner

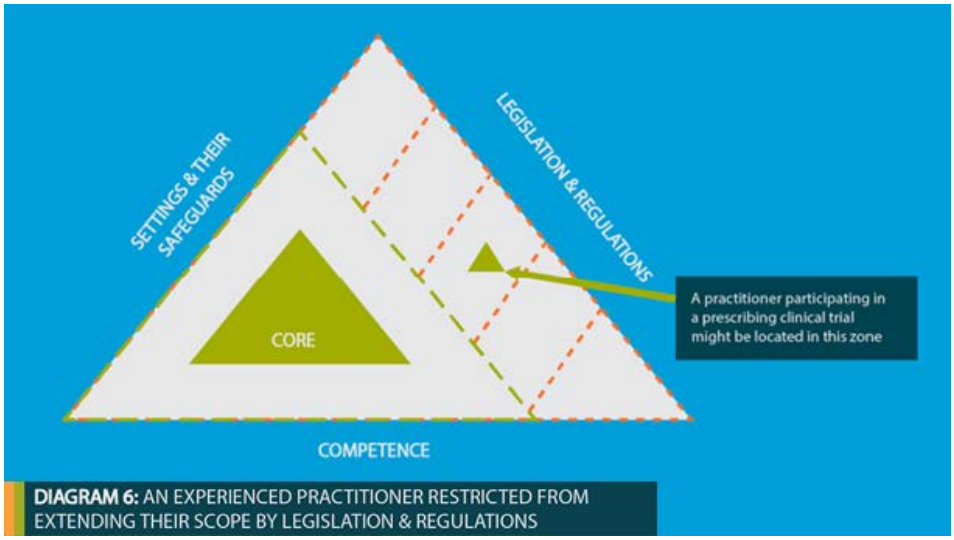

DIAGRAM 6: AN EXPERIENCED PRACTITIONER RESTRICTED FROM EXTENDING THEIR SCOPE BY LEGISLATION & REGULATIONS

An experienced practitioner might work in a specific setting where they are working on the edges of or beyond the traditional scope of practice and working with a high level of competency, or there might be opportunity to develop and demonstrate expertise. However, they will be restricted in extending their scope by legislation and regulations. For instance, a physiotherapist who is able to prescribe medicine in controlled trials in a hospital setting.

Summary

Scope of practice needs to be dynamic in order to facilitate opportunities available to physiotherapists to work at the top of their scope. As a result, our model is not prescriptive.

While it is underpinned by professional competence, we have considered aspects of scope of practice (such as the work setting, and legislation and regulations) to state our position on concepts such as sharing and declaring our professional practice, and advancing and extending our scope of practice.

By taking a collective and individual view of physiotherapy, the intention is to situate physiotherapy as a profession in relation to other professions, and to situate physiotherapists in relation to our peers in the profession and our colleagues in health.

Describing the frontiers of physiotherapy highlights the possibilities for students and early graduates of physiotherapy when they are envisioning the future of their practice. It also highlights the possibilities for innovators in our profession and those who seek to use their wisdom to strengthen the profession for the benefit of all Australians.