

THE CHARTERED SOCIETY OF PHYSIOTHERAPY

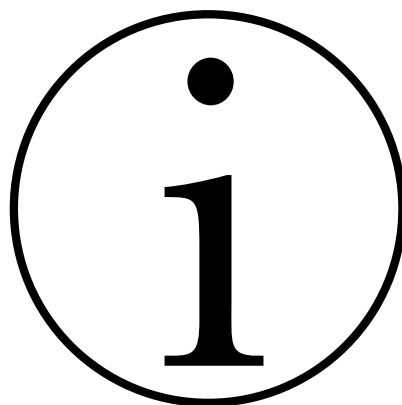
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Specialisms And Specialists: Guidance For Developing The Clinical Specialist Role

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The primary aim of the paper is to provide information and guidance for members wishing to develop physiotherapy clinical specialist posts within the employed sector. It is recognised that outside the employed sector, physiotherapists with many or all of the skills highlighted in section 4 will also call themselves specialists. The existence of this paper, however, does not preclude the use of the term specialist being used in a more commercial environment.

The paper is divided into the following sections:

1. Current situation
2. Clinical career structure
3. Specialisation within physiotherapy;
4. What is a specialist? - terminology, qualities and role;
5. The added value of clinical specialists;
6. Practical examples of clinical specialist roles.

1. Current situation

Consideration of the current situation regarding physiotherapy specialisation in the UK suggests that specialist posts are developing in an ad hoc manner, tending to reflect local service needs and recruitment/retention issues. Currently, specialist status is not formally recognised within the profession. The NHS grading structure also does not define the responsibilities of such posts with the result that the nature of specialist posts within the NHS is diverse, and remuneration is at the local manager's discretion.

Recognition of specialist status should benefit the profession as a whole by increasing its body of knowledge and expertise, for example, and by providing alternative career pathways for certain individuals. The creation of an increased number of clinical specialist posts will also provide the profession with clinical leaders, enabling it to address more readily key issues (for example, clinical effectiveness and evidence-based practice) relating to its development. Achievement of specialist status may also benefit the individual in terms of personal achievement, and if linked to the grading structure within the profession, should also provide financial reward.

2. Clinical career structure

The government has formally recognised the need for a clinical career structure within the NHS. Implementation of the recent NHS reforms will create opportunities for physiotherapy services to develop clinical specialist, extended scope practitioner and consultant posts.

Clinical specialists, extended scope practitioners (ESP) and consultant therapists are all examples of advanced clinical practitioner grades. The quality of advanced clinical reasoning will be a common quality for all advanced practitioner grades, although the roles, responsibilities and overall profile of each post will vary as illustrated in Figure 1.

Figure 1 illustrates the profile of a clinical specialist and an ESP and relates these roles to the Dreyfus model of skill acquisition (section 4). The clinical specialist works within a particular field (e.g. paediatrics, sports medicine) and their practice falls within the scope of practice of physiotherapy. The degree of specialisation may vary according to the individual's role: a clinical specialist in the community will have a broader scope of practice than a clinical specialist in haemophilia for example. The extended scope practitioner is a clinical specialist with an extended scope of practice i.e. certain elements of their role fall outside the scope of physiotherapy practice (refer to PA29 Chartered Physiotherapists working as Extended Scope Practitioners for further detail). Both roles could be used as a route to the consultant post.

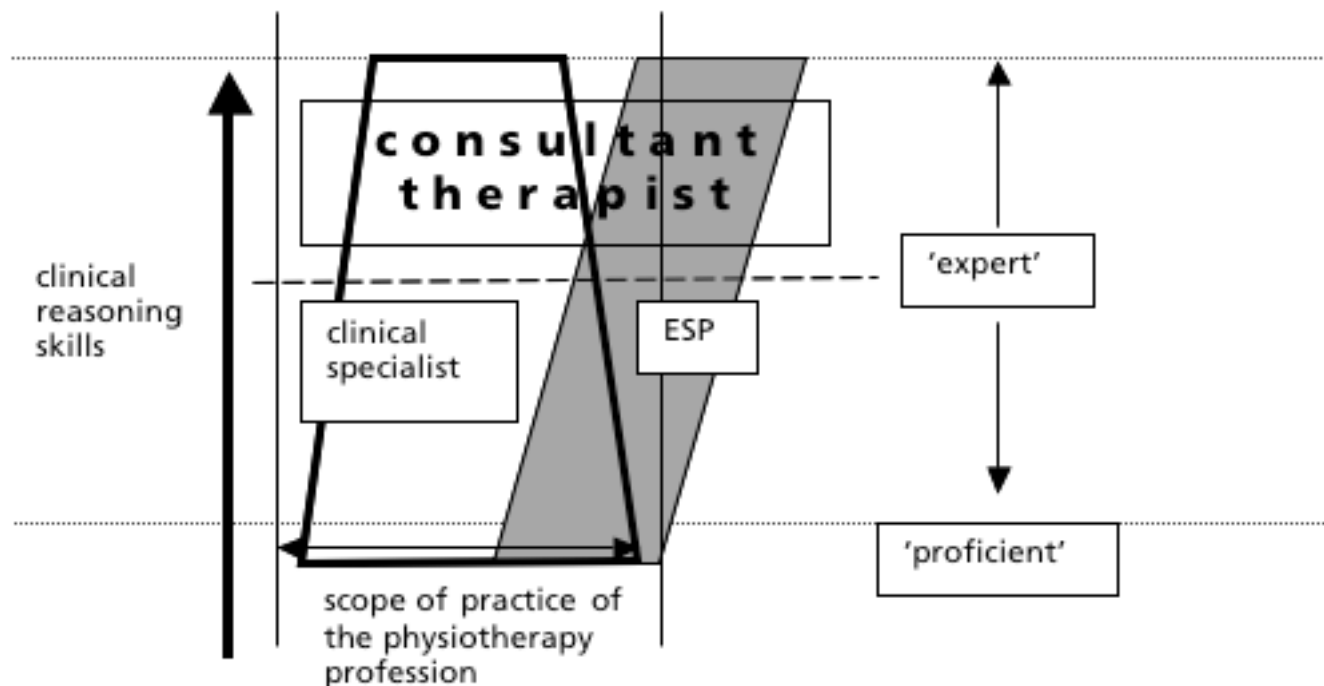


Figure 1: Profile of clinical specialist and ESP and their relationship to consultant AHP

3. Specialisation within physiotherapy

Specialisation is an evolving process within physiotherapy in the UK, which can be attributed to a range of factors both from within and from outside the profession:

- Advancements in medical knowledge and technology has facilitated the development of specialist services (including physiotherapy) to manage various patient groups such as paediatric intensive care or neurosurgery for example (Rivett 1998);
- Re-organisation of healthcare services and the evolution of medical expertise in ever-more complex and narrow fields of practice has increased the demands for specialists in other healthcare professions, such as physiotherapy (Wheeler & Grice 1996);
- The evolution of post-qualification education programmes (both formal and informal) has provided physiotherapists with a means of expressing their specialist knowledge, thereby facilitating recognition of clinical specialisms within the profession. The developments in postgraduate education have particularly facilitated this process;
- It could be argued that the blurring of professional boundaries may have reinforced the profession's need to annotate the boundaries by naming specialisms and creating individual posts to fight the territorial boundaries. Laffin (1990) adopts this view in his reflection on the UK engineering profession: "Increased specialisation is a typical defence strategy adopted by professional bodies when they see their profession being eroded' and when they wish to enhance their 'market position'".
- To date, the clinical career structure within the NHS has been relatively flat. The Whitley enabling agreement (1996) has facilitated career progression into the superintendent grades for physiotherapists working at a clinical specialist level;
- An increasing awareness by service users and providers, and educators of the need for highly skilled health professionals who can respond to, and influence, changes to practice and service delivery (Donaghy & Gosling 1999).

4. What is a specialist?

Terminology

The Dreyfus model of skill acquisition identifies five stages of progression (Benner 1984): novice; advanced beginner; competence; proficiency; and expert. A competent practitioner copes with many clinical contingencies, although lacks speed and flexibility in practice (Railstone 1994). It could be argued that this is true of newly graduated physiotherapists; competence is gained by further experience, reflection on practice and other CPD opportunities. The expert in the Dreyfus model has extensive experience, an intuitive grasp of the situation, and focuses intervention without wasteful consideration of other possibilities (Railstone 1994).

Roskell (1998) argues that expertise is an elusive concept, often measured in terms of length of clinical experience, seniority and academic qualifications rather than actual knowledge, skills and qualities.

The debate about the terminology is ongoing: are the terms 'specialist' and 'expert' synonymous? Donaghy and Gosling (1999) argue that an expert need not be a specialist:

- experts might have many years experience in a specialist field, but may not have undergone any formal assessment of their knowledge and skills;
- the expert's body of knowledge may not fall neatly into a specified area of practice.

'Specialist' could be interpreted to imply that the individual is practising within a defined area or specialism. Crawford-White (1996), writing about Occupational Therapists, compares a specialist and a generalist practitioner. 'A specialist is one who is devoted to a special branch of learning while a generalist is one whose skills extend to several different fields'.

Adopting this definition of specialist would be limiting to the individual practitioner and the patient, as a specialist can only function within a specified framework of expertise: their knowledge base is not valid outside this area. Furthermore, the development of specialists in certain areas may be limited. Access to patients within a particular field may not be adequate to enable the practitioner to gain experience on a regular basis for example.

Qualities

Literature (Jasper 1994, King & Bithell 1998, van de Meene 1988), consistently highlights the quality of **advanced clinical reasoning** as separating the specialist from the competent practitioner. Clinical reasoning refers to the thinking and decision making processes associated with a physiotherapist's assessment and management of a patient (Higgs 1990). It is therefore related to the individual practitioner's exposure to learning, clinical practice and clinical experience.

Figure 2 illustrates the relationship between these concrete processes of learning experience and clinical practice with more abstract activities of reflection and interpretation. The evolutionary process of clinical reasoning is applicable to all physiotherapy practitioners, regardless of occupational area and grade. This figure represents an ever-increasing spiral of complex interconnections, the result of which is advanced clinical reasoning. It is likely that the actual process of achieving advanced clinical reasoning will vary from one practitioner to the next, reflecting the opportunities and resources available and also the different methods in which practitioners gain knowledge.

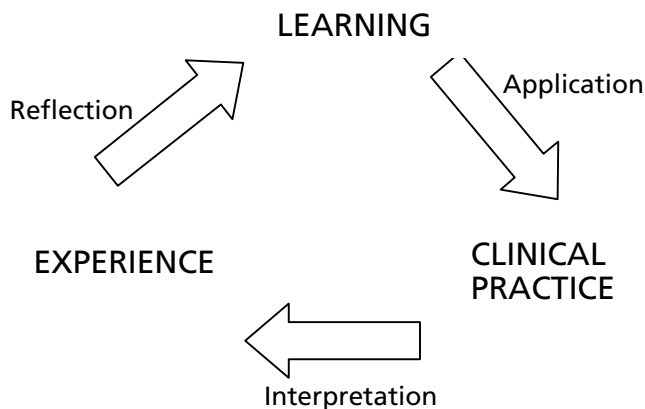


Figure 2: Spiral of clinical reasoning

Measuring advanced clinical reasoning is more complex than describing the process of acquiring the quality; this is attributable to its abstract nature (Jasper 1994). Educational programmes at an under-graduate and post-graduate level, however, have developed methodologies to assess students' clinical reasoning skills. Peer review is another means of assessing clinical reasoning skills. Guidance on carrying out peer review is included in the audit tools document of the CSP Standards of Physiotherapy Practice pack.

Jensen et al (1999) propose a theoretical model of expert practice which links knowledge and clinical reasoning to movement (a key element of physiotherapy practice) and virtues (caring and commitment). Each of these four elements interact to inform this therapist's vision of practice, i.e. what it means to practice physiotherapy and the purpose of physiotherapy for patients.

If the physiotherapy profession is to embrace specialisation in a formal manner, any recognition of specialists will require an agreed definition that can measure the abstract quality of advanced clinical reasoning. This definition should clarify the true nature of a specialist and clarify the differences between this status and that of an experienced practitioner working in a specific area (Carr & Shepherd 1996). Whilst the criteria should be rigorous, the process should not be elitist.

The role of a clinical specialist

The Chartered Society of Physiotherapy defines a specialist as a physiotherapist who works at an advanced clinical level within a specific clinical field. Their practice will be underpinned by advanced clinical reasoning. The clinical specialist's role encompasses four elements - clinical expertise; clinical teaching, evaluation; and practice/service development.

Figure 3 illustrates the interlinking of the four elements of a clinical specialist's role. All aspects of the role have a degree of overlap, the core element being clinical expertise, which is underpinned by advanced clinical reasoning. The weighting given to each element will vary from one clinical specialist post to the next depending on the nature of the service and what the post is expected to deliver.



Figure 3: Clinical specialist profile

It is the responsibility of the individual to determine whether they fulfil the criteria for a specialist by a process of self-evaluation and peer-review. Rule 1 of the Rules of Professional Conduct (CSP 1996) reflects this ethos, as does the Society's approach to CPD (CSP 2000). Jasper (1994) also advocates this approach, arguing that recognition of a specialist needs to be by individuals who are qualified to make that judgement, such as peers or by other experts in similar or related fields. This system also facilitates a degree of flexibility, so that specialist-level performance can be recognised regardless of the individual's clinical field or occupational area (e.g. primary care, industry or the acute sector) and allows for development of such posts to reflect service needs.

Criteria for clinical specialist posts

The criteria outlined are not prescriptive, but are intended to illustrate examples of how a physiotherapist might demonstrate the fulfilment of a clinical specialist role for each of the elements outlined above. The profile of individual clinical specialist posts will include responsibilities from each element, **but the weighting attached to each element will vary to reflect the service need and organisational structure and the practitioner's own expertise/interests.**

Clinical practice

- Demonstrates advanced knowledge/skills and clinical reasoning;
- Evidence of dealing with complex cases within a particular field of physiotherapy practice;
- Provision of advice/support to physiotherapy colleagues on clinical practice issues.

Evaluation

- Active participation in research and/or clinical evaluation and audit;
- Evidence of critically appraising the knowledge base and applying relevant high quality evidence to change practice;
- Publication(s) within the clinical field in peer recognised journals/periodicals.

Teaching

- Delivery of physiotherapy in-service education across the region;
- Acting as a mentor or supervisor for physiotherapy colleagues;
- Participation in developing post-qualification education packages;
- Involvement in the delivery of teaching to physiotherapy and/or other professions at a qualifying and post-qualifying level.

Practice/service development

- Development of the clinical field with colleagues;
- Clinical supervision of senior members of the physiotherapy team within the clinical domain;
- Involvement in the local clinical governance agenda;
- Involvement in professional networks;
- Leading the physiotherapy service within a particular clinical field.

5. The added value of clinical specialists?

The evidence-base to support (or refute) the clinical specialist role is relatively small; this fact may reflect that such roles are a new phenomenon and the differences in nomenclature (e.g. whether the 'expert' in one study comparable to the 'clinical specialist' in another). The following references do not constitute a systematic review, but aim to reflect some of the debate occurring within the literature on this topic.

van de Meene (1988) concludes that the specialist physiotherapist (by virtue of their advanced clinical knowledge, clinical reasoning and evaluation skills) is able to contribute with more understanding at an advanced level to improve the health status of the society and individuals within society. Carr & Shepherd (1996) develop these views and argue that:

"Specialisation exists primarily to enhance the health of the community, but also to promote recognition in the community of the value of physiotherapy practice to the welfare of that community".

King and Bithell (1998) compared the clinical reasoning of a group of five physiotherapists who had undertaken a recognised formal specialist training programme and a group of five equally experienced physiotherapists who had not taken specialist training. The results of this small study showed clear differences in the patterns of clinical reasoning between the two subject groups. Those who had undertaken the formal education demonstrated patterns of clinical reasoning which enabled them to formulate hypotheses which they tested in order to diagnose patients.

Jenson et al (1999) offer a different model of clinical reasoning in their qualitative study of twelve peer-designated experts in physical therapy. The experts in this study collected data from the patient, whilst simultaneously recalling relevant information from a databank of previous similar cases, before recognising the implications of the collective information and arriving at a diagnosis and treatment plan.

Schön (1984) raises the risk of professional burn-out of specialists, especially in view of the paucity of ongoing peer support and access to appropriate learning opportunities. Networks are already in place within the profession which could provide this type of support for specialists (the clinical interest/occupational groups for example), but such roles would need further development and formalisation. Consideration should be given to peer review and clinical supervision as a means of supporting specialists.

A range of other debates have arisen as a result of the evolution of specialisation and clinical specialists. One perspective questions the capacity of the profession to develop specialisation. Heater (1992) reflected that Occupational Therapy in the USA does not yet have sufficient self-knowledge and awareness and underpinning paradigms, to sustain a movement into specialisation and asks:

"Should we not first establish occupational therapy as a speciality in health care promotion before we presume to apply occupation to speciality practice areas?"

van de Meene (1988) in her reflections on the physiotherapy profession in Australia, offers a counter-argument:

"A profession which does not develop expertise and participate in its own body of research will disappear".

6. Conclusion

Anecdotal evidence suggests that clinical specialists benefit service delivery as well as providing clinical career progression opportunities for individual physiotherapists. In setting up clinical specialist posts consideration should be given to the following:

- structure of the post;
- support available to the post-holder including access to peers, CPD opportunities and other resources;

- possibilities of career progression within the role - evolution of consultant AHP;
- professional and managerial accountability issues.

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Appendix 1

Examples of clinical specialist roles

The roles outlined below have been taken from clinical specialist job descriptions and are intended to give an indication as to how individuals may fulfil the clinical specialist role as outlined in section 4 of this paper

Example 1: Respiratory Care

- To develop, co-ordinate, monitor and audit the service in collaboration with the Head of Physiotherapy Services, the Cystic Fibrosis Unit Clinical Director and Service Manager;
- To assess patients referred to the Cystic Fibrosis Unit alongside the consultant and his team in the respiratory care clinics;
- To undertake an appropriate clinical workload from those patients and ensure appropriate physiotherapy treatment by leading a team of physiotherapists: Senior I and Junior physiotherapists (in-patient) and Senior II physiotherapist (pulmonary rehabilitation).

Example 2: Learning Difficulties

- To provide physiotherapy treatment and advice for adults with Learning Difficulties;
- To provide specialist support for other agencies, including staff in Community Resource Units;
- To be responsible for the education and support of community physiotherapists in the Trust and the clinical management of junior staff;
- To be responsible for the service provision and assist with developments within the directorate

Example 3: Trauma and Orthopaedics (T&O)

- Management of a small personal caseload of complex T&O patients;
- Joint treatment sessions and goal planning with all other grades of physiotherapy staff working on T&O;
- Assessment, advice and where appropriate treatment of patients with orthopaedic conditions in other areas of the hospital and Trust e.g. ITU;
- Ensure physiotherapy practice in T&O is effective and evidence based by literature review, implementing audit and using outcome measures;
- Education and training of physiotherapy staff on T&O;
- Organisation, implementation and evaluation of an in-service training programme, both theoretical and practical for all grades of nursing staff on the T&O unit.

Example 4: Palliative care

- To be responsible for the provision of a high quality physiotherapy service to in-patients and outpatients of the hospice. This will include management of the lymphoedema service (multidisciplinary team) and co-ordination and supervision of the manual handling training programme;
- Provide expert knowledge and advice to colleagues and others within and outside the organisation;
- To participate in education/teaching in related areas.