

Physiotherapists in cardiac and pulmonary rehabilitation – sharing the rehabilitation space with clinical exercise physiologists?

EXERCISE AS CORE BUSINESS

Exercise has been central to physiotherapy, providing one of the most effective therapeutic interventions used by physiotherapists to improve the health and function of people with conditions ranging from acute musculoskeletal injury to chronic illness (e.g. cardiopulmonary diseases). As physiotherapists, we aim to maximise the potential of movement, function and quality of life of individuals across the age continuum, regardless of their health condition and complexity, and environment (World Confederation for Physical Therapy, 2015); exercise is therefore core business.

More recently in New Zealand (NZ), there has been a growth in the number and services provided by clinical exercise physiologists whose business is also exercise. Described as individuals who provide ‘specialised’ exercise and lifestyle education to people across the health continuum including people diagnosed with cardiovascular and respiratory disease (Clinical Exercise Physiology New Zealand, a, n.d.), clinical exercise physiologists have begun to share the rehabilitation space in areas such as cardiac and pulmonary rehabilitation.

VACUUM

Current international guidelines for cardiac and pulmonary rehabilitation programmes include a significant exercise component (Alison et al., 2017; Association of Chartered Physiotherapists in Cardiac Rehabilitation, 2015); historically exercise has traditionally been prescribed by cardiorespiratory physiotherapists (Association of Chartered Physiotherapists in Cardiac Rehabilitation, 2018; Best Practice Advocacy Centre New Zealand, 2017). These roles, and by association sustainability of services, are challenged by a decline in the number of cardiorespiratory physiotherapists despite an increasing prevalence of individuals with cardiac and respiratory conditions. Concerns have previously been raised regarding the future of cardiorespiratory physiotherapy in NZ and Australia due to issues with recruitment and retention, compounded by reduced student interest in specialising in cardiorespiratory physiotherapy (Reeve, Skinner, Lee, Wilson, & Alison, 2012). Such concerns continue as demonstrated with less than five per cent of respondents to the Physiotherapy Board of NZ annual 2013/2014 workforce survey indicating they worked full-time in in-patient and less than two per cent in out-patient cardiorespiratory physiotherapy in District Health Boards (DHBs) throughout NZ (Physiotherapy Board of New Zealand, 2016a). Job vacancies in DHBs for experienced physiotherapists also remain vacant, with many DHBs attempting to recruit from overseas (McLean, Valentine, & Shaw, 2017). Challenges relating to present and future numbers of cardiorespiratory physiotherapists, in a context of growing service demands for exercise-based cardiac and pulmonary rehabilitation, have therefore created a vacuum for other exercise-based professionals to fill. This was recently highlighted when, in

February, a NZ District Health Board advertised opportunities for clinical exercise physiologists to provide exercise programmes for people with chronic and complex conditions including cardiac and respiratory (Clinical Exercise Physiology New Zealand b, n.d.). The question raised is, can the rehabilitation space be shared or do we care enough to protect our role?

CREEP

While clinical exercise physiology as a profession is well established in Australia and other countries such as the United States, Canada and South Africa, the profession is just emerging in NZ. In Australia, the growth of the profession has been exponential in terms of graduates and schools; already this trend is apparent in the increased number of universities and institutes providing exercise physiology courses in NZ. This is evident in a report published for Health Workforce New Zealand advocating for the growth of clinical exercise physiologists in NZ with a focus on developing health career pathways (Rankin, 2014). Already privately-owned clinical exercise physiology services are being marketed to cardiac and pulmonary populations, targeting physicians, general practitioners and consumers.

While the opportunity exists for clinical exercise physiologists to extend into the ‘market’ of people with cardiac and pulmonary conditions, the future role and visibility of cardiorespiratory physiotherapists in exercise-based cardiac and pulmonary rehabilitation in NZ already seems less secure. The impact extends beyond current and traditionally held roles but has the potential to impact on undergraduate student placements in cardiac and pulmonary rehabilitation, particularly if physiotherapy and clinical exercise physiology students compete for placement hours. Of note, a minimum of 180 and 120 clinical hours in cardiovascular and respiratory conditions respectively are required as clinical experience for clinical exercise physiology training (Rankin, 2014). While Reeve, Skinner, Lee, Wilson and Alison (2011) have highlighted the need for increased quality clinical placements and educational opportunities to entice more potential graduates into the area of cardiorespiratory physiotherapy, the potential lack of placement availability in areas of cardiac and pulmonary rehabilitation may further negatively impact on recruitment and retention. Consequently, the vacuum may increase and with it the possibility of physiotherapy becoming less visible, to referrers and consumers alike.

INVISIBILITY

There is evidence that the visibility of physiotherapy in current NZ cardiac and pulmonary rehabilitation guidelines and literature has begun to fade, with increased involvement of other professions in exercise-based rehabilitation. Benatar, Doolan-Noble and McLachlan (2016), for example, describe many NZ based cardiac rehabilitation exercise programmes as “generally run by physiotherapists or clinical exercise physiologists who

are qualified to prescribe exercise after a functional test" (p. 69). They also refer to staff qualified to prescribe exercise and provide advice as an "exercise specialist (Physio or clinical exercise physiologist)" (p.69). Of note, this represents a paradox given that as physiotherapists, we can only be called specialists under the specialist scope of practice (Physiotherapy Board of New Zealand, 2016b) yet clinical exercise physiologists are marketed as individuals who both specialise in the delivery of exercise, and also that the exercise is specialised (Clinical Exercise Physiology New Zealand a. n.d.). Further evidence is found in a survey of cardiac rehabilitation in NZ by Kira et al. (2016), who noted that patients were referred to discuss exercise/activity with "a physiotherapist/exercise professional" (p.55). Similarly, some of the literature providing clinical guidelines for Australian and NZ pulmonary rehabilitation make reference to "a physiotherapist or accredited exercise physiologist who is experienced in prescribing exercise-based rehabilitation" (Allison et al., 2017, p. 808).

Yet international best practice guidelines informing Standards for Physical Activity and Exercise in the Cardiovascular Population (Association of Chartered Physiotherapists in Cardiac Rehabilitation, 2015) and Clinical Guidelines for Pulmonary Rehabilitation in Australia and New Zealand (Allison et al., 2017) are written almost exclusively by physiotherapists. This highlights the valuable role of physiotherapists in shaping practice and programmes for cardiac and pulmonary populations. So while physiotherapists may be becoming less visible in some rehabilitation programmes and literature, particularly in prescribing exercise, they remain present in shaping practice at an international level. What is not known is who is currently responsible for exercise components of cardiac and pulmonary rehabilitation in NZ? An area that also requires further investigation is the evolution of roles and responsibility within cardiac and pulmonary rehabilitation in NZ.

THE FUTURE

As physiotherapists, we have tended to 'rest on our laurels' and assume that traditional roles and responsibilities in cardiac and pulmonary rehabilitation will continue. Nicholls (2017) describes the critical point that now challenges physiotherapy and the threat to the long-held status of our profession, and by association, our core business of exercise. The increasing involvement of clinical exercise physiologists in cardiac and pulmonary rehabilitation, particularly with the growing population needs of people with cardiac and pulmonary conditions is one example. The question we must ask ourselves is what are we prepared to do as a profession to remain leaders and exercise prescribers in the areas of cardiac and pulmonary rehabilitation? This may involve rethinking our treatment approach of these populations, promoting and developing physiotherapy expertise in the areas of cardiorespiratory physiotherapy and exercise rehabilitation, and providing quality student placements. If nothing is done, the risk is that exercise as core physiotherapy business, will become the business of others in this valuable rehabilitation space.

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