

Clarifying the concept of advanced practice in physiotherapy for global model development

A nebulous concept in countries where advanced practice is not yet implemented

Advanced practice in physiotherapy (APP) is a model of care practice in which a practitioner can perform multi-faceted areas of practice, including medical and non-medical acts (advanced clinical reasoning, diagnosis, treatment planning and skills such as prescribing medication or triaging) [1]. Although APP models have been shown to be safe and to meet health targets in different health settings [1,2], and are well established in several Anglo-Saxon countries [1], they remain conceptually nebulous. The confusion stems from the organic evolution of the concept, leading to multiple meanings (numerous titles), several existing forms (various knowledge and 'know-how') and purely contextual applications [1]. Although current definitions [3,4] are inclusive and broad, they often fail to capture the essence of the concept in full. They are frequently constrained by the specific realities of health systems, which can vary significantly, even within the same country, and sometimes include practices that cannot universally be considered 'advanced', such as imaging prescription. This lack of clarity is detrimental to the building, recognition, dissemination and implementation of coherent models in new worldwide settings, particularly as the Anglo-Saxon countries have defined (and frozen) the concept of APP according to their own specific context and history. Moreover, a clearer circumscription of the concept of APP would help to better define interprofessional boundaries and continuum, avoid excessive fragmentation of healthcare professions, and ensure that practices are structured by federating countries around a common vision before adapting the APP model to the needs of a specific country. For instance, in countries such as Belgium and France, where APP is still emerging and regulatory frameworks remain limited, developing an APP model is challenging. This often results in simply transposing existing Anglo-Saxon models, which may not align with the local context. The aim of this editorial is to clarify the concept of APP by offering a complementary perspective to existing definitions with a view to operationalise the concept for stakeholders seeking to develop models tailored to their national contexts.

Key dimensions to circumscribe the concept

A universal definition does not reflect the full range of subtleties involved in the creation of an APP model.

Therefore, refining existing definitions with greater nuance seems more constructive and useful than adding to the current ambiguity. To this end, we propose four essential dimensions [3,5] to delimit the concept.

In the first dimension, advanced practice supplements basic training by deepening knowledge, skills and expertise. This aspect underscores the meaning of the term 'advanced', highlights the required higher level of expertise and practice [6], and positions the concept within the educational trajectory of health practitioners. In APP models, patients initially present expecting to see a physician, but are instead managed by an advanced practitioner. This practitioner could assume several roles such as coordinator, researcher, teacher and clinician, with expanded responsibilities that include directing patients towards the optimum care pathway, as in the National Health Service (NHS) system [1,3,7]. In the second dimension, APP responds to specific needs of health systems or populations [8]. It emerges as a response to the limitations, inefficiencies or evolution of existing systems, with the goal of improving access and care quality, and controlling costs

[1]. In this regard, APP represents a solution-oriented approach through development role expansions. APP practitioners aim to optimise their work setting and healthcare systems, setting the concept apart from specialisations or manual therapy [1]. In the third dimension, APP conveys a 'propensity for autonomy', responsibility and upstream access [9]. APP has symbolic and political significance because it illustrates a desire for emancipation and expansion of the scope of physiotherapists' skills by asserting their expertise. In the fourth dimension, it is essential for the APP concept to remain flexible to best adapt to the context in which it is implemented. This enables the creation of optimised models for each setting that respond to current healthcare trends globally. Finally, APP must be clearly distinguished from both 'direct access' (which does not go beyond the scope of the physiotherapist's profession) and clinical specialisation (in-depth study of a particular area of physiotherapy) [10].

Operationalising the concept in different healthcare systems

Keeping the dimensions in mind, countries interested in the creation and implementation of an APP model should ask, 'Does the healthcare system require or is it favourable to APP?' Indeed, in countries with a high physician density, we may question whether the prerequisites for the emergence and long-term sustainability of APP are met. The first and second dimensions ask 'What roles and practices are needed to match with the system's needs and context realities?', because each new role creates organisational challenges and reluctance. In view of the third dimension, 'What level of autonomy and responsibility is permitted and/or should be created for this profession according to our political vision?' [11], because these values are not necessarily popular with all stakeholders. Considering flexibility, each country should determine how to structure its own model, considering its specific system constraints, instead of adapting an existing model. Is it necessary to take on all four roles in the NHS system, for example? This involves asking whether APP constitutes a new profession [12], or rather an extension of existing professional boundaries or part of a continuum of development of a single profession, for instance. In countries where the political fragmentation and diversity of healthcare settings may hinder the emergence of a unified APP model, a modular approach could arise, fitting (or not) with the current official definitions or the NHS-system-embedded recommendations (such as the advanced practice maturity matrix or the advanced practice capability framework) but corresponding to the dimensions cited if it is adjusted (designed to fit) to its particular environment (local or national). In either case, APP offers an opportunity to rethink professional roles, interprofessional collaboration, and the future of healthcare delivery.

Conflict of interest

None declared.

References

- [1] Tawiah AK, Desmeules F, Finucane L, Lewis J, Wieler M, Stokes E, et al. Advanced practice in physiotherapy: a global survey. *Physiotherapy* 2021;113:168–76.
- [2] Rolving N, Kræmmer J, Rafaelsen C, Jørgensen CK, Andersen ED, Sauer AT, et al. Effect of involving physiotherapists in the management of low back pain at emergency departments: a systematic review. *Physiotherapy* 2025;127:101454.
- [3] Chartered Society of Physiotherapy. Advanced practice in physiotherapy. London: CSP; 2018 [Available at: (<https://www.csp.org.uk/documents/alpinphysiotherapyfinalpdf>)].
- [4] World Physiotherapy. Policy statement: advanced physical therapy practice. London: World Physiotherapy; 2023 [Available at: (<https://world.physio/policy/ps-advanced-pt-practice>)].
- [5] Herrington J, Soever L, Desmeules F, Farrer C, London K, MacLeod A, et al. The future is now for advanced practice physiotherapy in Canada. *Physiother Can* 2024;76:1–3.
- [6] Desmeules F, Roy JS, MacDermid JC, Champagne F, Hinse O, Woodhouse LJ. Advanced practice physiotherapy in patients with musculoskeletal disorders: a systematic review. *BMC Musculoskelet Disord* 2012;13:107.
- [7] Chang AT, Gavaghan B, O'Leary S, McBride LJ, Raymer M. Do patients discharged from advanced practice physiotherapy-led clinics re-present to specialist medical services? *Aust Health Rev* 2018;42:334–9.
- [8] Warrington K, Kennedy CA, London K, Soever LJ, Brooks SC, Passalent LA, et al. The patient perspective: arthritis care provided by advanced clinician practitioner in arthritis care program-trained clinicians. *Open Access Rheumatol* 2015;7:45–53.
- [9] Evans C, Poku B, Pearce R, Eldridge J, Hendrick P, Knaggs R, et al. Characterising the outcomes, impacts and implementation challenges of advanced clinical practice roles in the UK: a scoping review. *BMJ Open* 2021;11:e048171.
- [10] Bicker G, Hadley-Barrows T, Saunders A, Mairs H, Stevenson K. A narrative synthesis of the effectiveness and acceptability of musculoskeletal first contact physiotherapy practitioner roles in primary care. *Musculoskelet Care* 2024;22:e1875.
- [11] Nemeth T, Lamers I, Meesen R. Entry-level education for physiotherapists in Europe: a narrative on the relationship with professional autonomy. *Physiotherapy* 2025;128:101801.
- [12] Dubar C, Tripiet P, Boussard V. *Sociologie des professions*. Paris: Armand Colin; 2015.

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