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CORRESPONDENCE

Comments on: Impact of direct access on the quality of primary care musculoskeletal physiotherapy: a scoping review from a patient, provider, and societal perspective

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The « Coupole » includes the Royal Belgian Society of Physical and Rehabilitation Medicine (RBSPRM), the Belgian Association of Medical Unions (Absym), and the Belgian Group of Specialists (GBS)

Dear Editor,

We read with interest the scoping review by Cattrysse et al. (1) on the impact of direct access (DA) to physiotherapy for musculoskeletal disorders. We acknowledge the authors' efforts but would like to share our concerns about several critical issues.

This review includes five systematic reviews with a significant risk of bias (cf ROBIS tool), without meta-analysis, and four primary studies, none of which are controlled, randomized prospective clinical trials, published in low-impact and/or suspected predatory journals. Most report short-term outcomes, making the level of evidence for DA conclusions quite low.

The first step in treating musculoskeletal disorders is establishing a diagnosis, requiring extensive medical training to distinguish serious disease from common disorders. Moreover, DA assumes that physiotherapy is the best therapeutic option for musculoskeletal disorders, which is not always the case. Some conditions require alternative or complementary treatments that only a physician can properly assess and prescribe. A holistic patient assessment is essential to avoid misdiagnosis or delayed diagnosis, which can have serious consequences. In many countries, only doctors are trained and authorized to diagnose. However, their training in musculoskeletal disorders—often seen by general practitioners—should probably be improved. Physiotherapists' training varies widely by country and even within countries, with some acquiring musculoskeletal skills through additional training, leading to significant variability in their diagnostic and management abilities. The authors highlight red and yellow flags in low back pain but do not sufficiently address misdiagnosis risks. (2) Red flags were developed to help doctors identify rare symptomatic low back pain among common cases, but they are not diagnostic criteria, have poor sensitivity and specificity, and do not replace clinical reasoning. (3,4)

This study does not consider key contextual factors such as health system structure, economy, availability of health professionals, training disparities, and medical/paramedical practice regulations. Care organization is also crucial: do disciplines work in isolation or within structured networks? Thus, clinical trial results from one country should not be extrapolated to another or used for policy decisions without careful consideration.

Moreover, many healthcare systems lack an independent regulatory body for physiotherapy, unlike the Medical Council governing physicians. This absence raises concerns about clinical practice monitoring, professional standards enforcement, and handling of medical errors or complaints. Any DA consideration should include creating or strengthening such regulatory bodies to ensure patient safety and professional accountability.

The review suggests DA physiotherapy may reduce consultation, imaging, and medication costs but lacks rigorous economic analysis. No health economist contributed, and hidden costs (e.g., delayed diagnoses or inappropriate treatments) were overlooked. Additionally, claims that no significant adverse events were reported are weakened by limited patient safety data on diagnostic errors or missed serious conditions. Without robust safety data, stating that DA physiotherapy is as safe as physician-led care is premature.

In conclusion, while this review presents potential DA benefits, its limitations cannot be ignored. High-quality clinical and economic studies are needed to assess DA risks and benefits properly. A cautious, well-regulated approach prioritizing interdisciplinary collaboration is essential to ensure safe, effective patient care. (5)

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