Clinician's Commentary on Larsen et al.¹

Community-acquired pneumonia (CAP) is a serious respiratory illness with significant individual and societal implications.² In Canada, CAP is a major cause of mortality;³ treatment often involves admission to hospital, especially for older adults.⁴ Physiotherapists working in hospital-based health care settings may therefore have many opportunities to be involved in providing care to individuals diagnosed with CAP.

In their recent systematic review, Larsen and colleagues¹ helped to highlight the role of physiotherapists working with individuals admitted to hospital with CAP by examining the effect of early mobility as a physiotherapy treatment for this population. This is an important topic to consider, especially because the role of physiotherapists and other allied health care professionals has traditionally not been considered in existing guidelines addressing the management of CAP.^{2,5}

Although medical interventions such as antibiotic therapy continue to be central to the treatment of CAP, additional supportive therapies have more recently been considered as part of recommended practice.^{6,7} Recommendations such as encouraging patients with uncomplicated CAP to spend time out of bed and be progressively mobile early in their hospital stay,⁶ as well as physiotherapists' and occupational therapists' involvement in addressing issues with mobility and the performance of activities of daily living,⁷ are well aligned with more comprehensive and collaborative interdisciplinary models of health care.

Physiotherapists are well versed in the benefits of being physically active and the negative consequences of bedrest or prolonged physical inactivity. As a result, the potential physiological and functional benefits of initiating early mobility for individuals with serious acute illnesses such as CAP are easy to conceptualize. Larsen and colleagues¹ summarize many of these potential benefits, such as promoting airway clearance, preventing muscle weakness, and reducing the risk of physical activity intolerance and functional decline. In addition to these important considerations, it may also be prudent to consider the broader implications of patients' participation in early mobility, such as its potential impacts on cognitive functioning, social interaction, client engagement, and quality of life.

Although meta-analysis provided support that early mobility reduces the mean length of stay, it was not associated with reductions in mortality for individuals hospitalized with CAP.¹ However, these results must be interpreted in the context of a very limited body of evidence, which rarely considered functional or more qualitative, patient-centred outcomes. It is encouraging that early mobility in this population was also not associated with any harmful effects.¹

Larsen and colleagues¹ contextualize early mobility as a physiotherapy treatment for pneumonia; this is a logical approach, considering the role that physiotherapists play as experts in physical functioning and the treatment of physical dysfunction caused by disease. However, as the profession continues to embrace more comprehensive, collaborative, inter-professional models of care, it may be helpful to consider early mobility not only as a stand-alone treatment delivered within the unique

scope of practice of individual health care professions but also as part of their culture of practice, one that can be woven into many aspects of care delivered by inter-professional teams.

Care delivered in hospital provides frequent opportunities to engage clients in early mobility – for example, opportunities to eat meals while sitting up in a chair, to mobilize to the washroom rather than toileting in bed or using a bedside commode, and to participate in self-care activities such as bathing and grooming. Even something as simple as offering a change in position so that clients can sit up at the bedside while participating in common health care assessments, such as auscultation of the lungs or subjective interviewing, can offer them opportunities to be more mobile.

I support Larsen and colleagues'¹ recommendation for further trials providing early mobility interventions according to defined exercise protocols in order to further explore the clinical benefits and inform the development of best-practice guidelines for individuals with CAP. At the same time, I would invite us all to think more broadly about how early mobility can be promoted as part of routine interdisciplinary, hospital-based care. As experts in mobility and physical functioning, physiotherapists have a unique opportunity to advocate for more holistic approaches to early mobility and comprehensive care plans that embrace medically appropriate early mobility as a central tenet rather than a siloed, profession-specific or disease-specific intervention.

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