

The end of physiotherapy

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It is well understood but seldom remarked that physiotherapy intervention has no obvious or well-defined end point. There is a real sense in which there cannot be too much therapy since all, or almost all, people benefit both from exercise and from instruction in how to exercise safely given individual variables such as physical condition or age. In this sense, the relationship with the patient is 'open ended'. It is always possible for the patient to argue, and for the physiotherapist to feel, that increased benefit would have been obtained from further therapy. It is natural for both the patient and the therapist to feel that harm may be done if therapy is brought to an end prematurely. Given these well-known beliefs, it is perhaps surprising that to date there is no well-established or accepted theory which defines appropriate end points either for rehabilitation generally or for physiotherapy intervention in particular. While the aim of therapy appears clear, the point at which that aim is achieved is uncertain. Physiotherapists know where they are going without knowing when to stop!

Perhaps the most obvious end points are either the restoration of the patient to their condition prior to disease or injury, or, what will in many cases be more ambitious, the restoration of normal function. However, given that therapy is likely to occur in the context of injury or illness, and that there will be many impediments to both of these goals, it will often be unclear how realistic is the prospect of restoring either normal function or the *status quo ante*. More commonly, therapy will be offered for a limited period, defined perhaps by financial constraints or by the determination of the patient (or the determination of the physiotherapist).

The end point, therefore, will often be arbitrary in one way or another. The alternative, of continuing until it is not plausible to suppose that further benefit would be derived from therapy, would clearly be an unreasonably open-ended commitment. Another alternative, namely continuing as long as the patient desires or feels benefit from therapy, might be equally unrealistic in terms of cost or indeed the determination of the various parties. Usually what happens in the clinical setting is that therapy is ended due to practical or financial difficulties (inability of the clinic to accept many patients, or inability of the insurance company to cover the expenses), or because the physiotherapist or the patient believes that therapy should end. If decisions are not to be arbitrary, a theory – or at least some plausible account – of the end point of physiotherapy intervention is required. The physiotherapist needs to have a rigorous and reliable measure that guides decisions and supports actions.

Rehabilitation as a measure of how society cares for its citizens

Since rehabilitation – of which physiotherapy intervention is an important component – occurs at the stage at which fatal threats to life and health have been largely resolved, it may reasonably claim to be the branch of medicine most

concerned with the well-being and adequate functioning of citizens. Thus the extent to which a society provides and indeed funds rehabilitation is probably a good measure of the interest it takes in, and the importance it attaches to, the well-being of its citizens. Too often rehabilitation is regarded as a sort of optional extra, a luxury that can be tacked on to the end of more acute care. However, in our society, rehabilitation is an essential part of the caring process. It is an expression of concern for patients as people, as individuals who not only want symptoms treated and the threats to life removed but also want to function as well as possible for their own sake as well as for the sake of others, and of society more generally.

In providing care and protection for its citizens, a society demonstrates its respect for all those within its borders. Respect for people has two essential dimensions: concern for their welfare and also respect for their wishes, for their autonomy (Harris 1985). Welfare provisions, understood as a combination of all of the things that make life worth living (minimum standards of food, shelter, clothing, protection and so on), are essentially 'liberating'. They are the things that people need in order to be free to live their own lives, to make their own choices and function as human beings. An important part of this liberating effect of welfare is that people should feel that their functioning, their freedom, is not being constrained by barriers that care and protection could remove. In this sense, having liberated patients from the threats posed by premature death, pain, or disease, society has a duty not to leave them constrained by weakness or infirmity. It is precisely at this point that rehabilitation (including therapy) becomes not only important but a reflection society's care for its citizens.

Need for further reflection

There are three main points that the physiotherapy profession should reflect upon. First, it should examine the difference between physiotherapy intervention and medical intervention to reveal those attributes particular to therapy. Second, it should determine which notions of health, disease, and disability are applicable in the context of physiotherapy intervention. Third, it must recognise that the question of who establishes the measure of health or disability can have profound consequences.

Differences between therapy and medicine

There are differences between therapy and medicine and these differences may play an important role in determining the end point of physiotherapy intervention. In medicine, it is usually not difficult to recognise when the physician's duty stops. Therapy, for its part, aims not only to restore function but may aim as high as is possible in terms of health, welfare, or improvement of function since restoration and enhancement have no clear dividing line. Most often, therapy is not aiming to ameliorate life-threatening situations and it involves hard work and commitment from the patient. The

patient is not a passive receiver of the physiotherapist's care. It is not difficult to hold the view that the classical doctor-patient relationship is different from the physiotherapist-patient relationship. Whatever understanding we have about the first may not automatically be transferable to the second.

Defining health and disease in the context of physiotherapy intervention

Deciding what health and disease are is difficult. Two sources of disagreement emerge from the literature. One major debate concerns the role played by the determination of normality in the identification of disease (Caplan 1992). To determine what is normal there are two major views. The first suggests that because all organisms are the product of a long course of biological evolution, health is the functioning of any organism in conformity with its natural design; the other view holds that disease is anything that is statistically abnormal (Caplan 1997). The second area of disagreement concerns the role played by values in the definition of disease (Caplan 1992). Is disability a physical fact or a social prejudice? The world of disability theory is divided between those who insist it reflects a physical fact affecting life quality, and those who believe disability is defined by social prejudice, positions often referred to as the medical and social models (Koch 2001). For many thinkers both functional limitation and social discrimination can be a source of disadvantage (Hull 1998). The consequences of adhering to each of these definitions are considerable, and physiotherapists must know what is to be won or lost in each case.

The importance of who defines health and disease

Who it is that defines health and disease, in my view, is a matter for serious consideration. It is difficult to imagine a situation where a conflict due to scarce resources or inadequate finances for therapy will be resolved by mutual concession and agreement, for example, between the patient and the insurance company. Who defines health and disease is connected with who decides the allocation of resources or other important matters. Respect for a patient's rights requires that the patient has a significant voice in determining end points.

Therapy is liberating

The APA Code of Conduct states that: 'APA members shall define their scope of practice according to current knowledge and competency standards' (Australian Physiotherapy Association 2001). To define their scope, physiotherapists must be fully aware of the problems from which our profession suffers. To say simply that we aim for the welfare and autonomy of the patient is not enough. The whole process of deciding has more than one parameter. The patient must have an amplified role, a bigger part in the decision. The patient is not in a position to know in advance what welfare or disability is or, in other words, what the end point of rehabilitation could be. However, this knowledge becomes crucial when the need for an end point occurs. For that reason, all parties involved need to work together in order to make these notions clearer. It is important to prepare the way for an explicit discussion of the arguments upon which such a dialogue may take place, the problems involved and the answers suggested by the literature.

By its very nature, physiotherapy intervention requires

active participation on the part of the patient, and this fact calls for a more energetic role by the patient in decision-making about the end point of therapy. This decision may not coincide with the interests of insurance companies or hospitals. However, it is only by providing rehabilitation for its citizens that society demonstrates its respect for quality of life.

There is something *special* about therapy. If we ask what that is, the following ideas suggest themselves as part of the answer:

1. Therapy is *liberating* in a special sense. If immobility or inability to move joints, muscles, and limbs is confining, then therapy liberates patients.
2. Therapy usually involves a close physical relationship between the physiotherapist and the patient during a session.
3. Therapy usually requires the patient to be fully involved and work hard to succeed.
4. Therapy is not usually invasive and occurs at the stage where threats to life and health have been largely resolved.

All these characteristics stand explicitly and shout for special attention. It is only by realising therapy's uniqueness that society, physiotherapists, and patients will resolve the problems of finding its acceptable end point.

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