Primary care physiotherapy in the Emergency Department

Since the late 1970s when physiotherapists in Australia were first able ethically to undertake primary contact practice, ie to accept patients without medical referral, private sector practice has developed and flourished. It is estimated that, annually, there are some 5 million primary contact attendances occur in this way. However, while many of the patients presenting to public sector Emergency Departments have similar conditions, primary care practice has been slow to evolve in that area.

Only recently has it been recognised through the Department of Human Services Victoria Emergency Department reform program, and similar initiatives in other Australian states and territories, that physiotherapists have a significant role to play in managing soft tissue injuries in the primary care setting. Not only can the quality of care provided be improved, but ED physicians are freed up to undertake work which requires their specific knowledge and skills. Thus waiting times for all patient triage categories are reduced and the health workforce is utilised more effectively.

Until now the evidence for the benefits of this approach has been confined to the UK literature (Jibuke et al 2003, McClellan et al 2006), although there are several major studies of the Australian experience due to report in the near future. It is therefore most pleasing to see the report by Lau et al (2008) of their evaluation of early physiotherapy intervention for low back pain in an Accident and Emergency Department in Hong Kong. Their demonstrated outcome of a reduction in pain and improved satisfaction in this patient group adds further to the weight of evidence of the value of physiotherapists being employed in this setting.

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References

Jibuke O et al (2003) *Emerg Med J* 20: 37–39.

Lau P et al (2008) *Aust J Physiother* 54: 243–249.

McClellan C et al (2006) *Emerg Med J* 23: 384–387.

Sexual boundaries between physiotherapists and patients

The APA National Professional Standards Panel views with concern the findings of Cooper and Jenkins (2008) on professional sexual boundaries between physiotherapists and their patients.

In 2008, the Panel undertook a review of the APA Code of Conduct in consultation with a wide range of stakeholders including physiotherapists, Registration Boards, Health Service Commissioners, third party purchasers, Health Departments and – most importantly – consumer representatives. This consultation process made it abundantly clear that the APA needed to take a strong and clear stand on professional sexual boundaries for the benefit of physiotherapists and patients alike.

Accordingly, the APA Code of Conduct (2008) stipulates that APA members must respect the rights, needs, and dignity of all individuals. Two of the interpretations of this principle relate to professional sexual boundaries as follows:

- Members shall not engage in any sexual activity with a person who is a current client.
- Members shall not engage in any sexual activity with a person who is a former client where such activity would constitute exploitation of a professional relationship.

While Cooper and Jenkins (ibid) found that opinions on professional sexual boundaries differed where sporting teams and rural private practice were concerned, the APA takes the view that in almost every possible circumstance acceptable professional boundaries are immutable regardless of the setting in which the physiotherapy is provided. The APA argues that sexual relationships with patients are inappropriate because the power relations in the physiotherapist-patient relationship are inherently unequal and can give rise to exploitation of the patient. In addition, transgression of professional boundaries can impede the clinical judgement of the physiotherapist. Both these scenarios are profoundly counter to the principles in the APA Code of Conduct.

The National Professional Standards Panel notes that many Physiotherapists Registration Boards, including those in New South Wales, Tasmania, Queensland, Northern Territory, and Victoria, provide specific guidance material on professional sexual boundaries. Following the release of the Association's new Code of Conduct, the National Professional Standards Panel intends to develop complementary documentation on sexual boundaries to provide more detailed guidance for members and members of the public.

Cooper and Jenkins (2008) argue that more information is needed about complaints processes. The Panel notes that such information is available on the APA website as well as on the websites of Physiotherapists Registration Boards. Any complaint involving an alleged transgression of professional boundaries should be referred to the relevant Physiotherapists Registration Board or to the police depending on the circumstances. The APA does not investigate such complaints in the first instance because the Association considers it preferable for such matters to be investigated independently by the relevant statutory authority. However, where such a complaint results in a criminal conviction or a ruling of unprofessional conduct against a member of the Association, the National Professional Standards Panel investigates the physiotherapist's ongoing eligibility for APA membership.

Physiotherapists who are members of the APA are making a public commitment to professional accountability and to high standards of ethical and professional conduct including respect for professional boundaries. The Association has a responsibility to protect this valuable standing.

Patrick Maher
Chair, APA National Professional Standards Panel

References

Cooper I, Jenkins S (2008) *Australian Journal of Physiotherapy* 54: 275–279.

APA Code of Conduct (2008) Camberwell: Australian Physiotherapy Association. [http://physiotherapy.asn.au/images/APA_Corporate_Documents/apa_code_of_conduct.pdf Accessed 12 January 2009.]

Ethics education will help clarify issues

The recent paper by Cooper and Jenkins (2008) raises some interesting and valuable issues for discussion. How physiotherapists perceive and respect sexual boundaries is an ethical issue. It concerns respect for the patient and respect for the nature of the fiduciary relationship where patients must necessarily rely on their physiotherapist to act in their best interests in treating, advising, or managing their health care.

Two points might be inferred from this paper. The first concerns the message communicated by the paper and the second relates to the profession's response to the issues raised by the study.

The authors' key message is that West Australian physiotherapists are not consistent in their judgement of what is acceptable in relation to sexual boundaries. The authors also conclude that sexual attraction between a physiotherapist and their patient may be experienced such that it may lead to the physiotherapist 'dating a current or ex-patient'. Although the findings appear to lead to these conclusions, their value is limited by two methodological weaknesses. The first, acknowledged by the authors, is that a response rate of 42% limits generalisability. This is an important limitation that should alert readers not to draw conclusions, based solely on this study, about the behaviour of all physiotherapists. The second is that, in responding to the vignettes, physiotherapists were limited to marking a number to represent what they thought about the ethical issues raised. This necessarily limits the ability of respondents to explain their understanding of the issue of sexual boundaries in therapeutic relationships, and the ability of the reader to interpret why therapists responded in this way.

Given these methodological considerations, a safer conclusion to draw is that there is some uncertainty about the nature of obligations arising from the therapeutic relationship, and that this uncertainty may put patients at risk. This conclusion is less definite than that of the authors, which pertained to physiotherapists rather than their patients. Further, this type of ethical uncertainty has been identified in other physiotherapy studies, including studies defining the nature of confidentiality (Waddington and Roderick 2002), recognising the obligations arising from informed consent (Delany 2007), and dealing with difficult patients (Potter et al 2003).

The authors suggest that the study might be replicated nationally and that regulatory bodies such as the APA and the (future) National Registration Body should 'develop a framework that provides details of the boundaries expected in a professional relationship…' Whilst these are valid responses to the problems identified on the face of the study results, the development of frameworks themselves is unlikely to achieve improvement in ethical practice and understanding.

The Australian Physiotherapy Association has engaged actively with the development of a code of ethics and has recently revised that code. All State and Territory Physiotherapy Registration boards have published codes of ethics and most provide ongoing information about expected standards of ethics in practice. It seems clear that additional guidelines and policies will not necessarily achieve a change in practice. Instead, what this study highlights is a need to develop ethics knowledge and practice in similar ways to the development of clinical knowledge and practice, that is, through building evidence-based knowledge and through ongoing education in the area of ethical clinical practice.

There is an emerging literature in physiotherapy suggesting that meaningful and practical clinical engagement with ethics requires something more active and grounded in everyday practice (Edwards and Delany 2008, Jensen 2005). Ethics education, by its nature, involves assisting practitioners to identify ethical issues and appropriate responses rather than just providing authoritative guidance. Effective ethics education should clarify important values in clinical practice, and assist students and experienced clinicians alike to recognise ethical issues, understand their personal responses to ethics in their clinical practice, and to recognise alternative responses. This is the message that really lies at the heart of this important and interesting paper.

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References

Delany C (2007) *Australian Journal of Physiotherapy* 53: 171–177.

Edwards I, Delaney C (2008) In Higgs J, Jones M, Loftus S, Christensen N (Eds) Clinical Reasoning in the Health Professions (3rd edn). Sydney: Elsevier.

Jensen G (2005). In Purtilo R, Jensen G, Brasic Royeen C (Eds) Educating for Moral Action. Philadelphia: FA Davis.

Potter M et al (2003) *Australian Journal of Physiotherapy* 49: 53–61.

Waddington I, Roderick M. (2002) *British Journal of Sports Medicine* 36: 118–123; discussion 123.