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The impact of recent health legislation on health care ethics: The physiotherapy perspective.

Sandy Elkin

A thesis submitted in partial fulfilment of the requirements of the degree of Master of Bioethics and Health Law

At the University of Otago, Dunedin, New Zealand

February 1999
Abstract

There have been many changes in the physiotherapy profession since its beginnings in 1894. The first purpose of this thesis is to explore the way in which these changes have brought new ethical dilemmas for the physiotherapist and to discuss the way in which these are similar to, and also different from, those encountered by the medical profession. Common concerns, such as informed consent, confidentiality, truth telling and the professional relationship will be discussed from both an ethical and a legal view point and will be related to clinical practice.

The second aim is to consider two recent pieces of New Zealand legislation – The Health Information Privacy Code and The Code of Health and Disability Services Consumer’s Rights. The way in which the legislation impacts on health care ethics will be discussed and also applied to physiotherapy practice.

In its conclusion the thesis will suggest that while the Code of Health and Disability Services Consumer’s Rights makes clear the duties of physiotherapists as health care providers there are problems with the application of the Code to the field of rehabilitation.
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Chapter 1: An historical overview of the development of physiotherapy overseas and in New Zealand

Physiotherapy, as a recently emerged profession, has undergone rapid growth and development since its beginnings in 1894. There has been a gradual move from diploma to degree education and with it an increasing recognition of the need to engage in research and postgraduate education. Consequently the knowledge base has expanded and continues to grow. There has been a move from physician prescription and referral to self-referral resulting in physiotherapists becoming first contact practitioners with increasing levels of professional autonomy and therefore increased professional accountability. These changes have brought with them a need for greater ethical awareness.

In order to understand the ethical problems which confront physiotherapists as they prepare for the twenty first century it is important to understand something of the beginnings of the profession and its subsequent development.

The nineteenth century saw many changes in the medical area. Advances were made in all areas including surgery, bacteriology and the development of nursing. There was also a renewed interest in the long neglected art of massage, or "medical rubbing". This was largely as a result of the migration to England of a number of Swedish men and women who had trained in massage and remedial gymnastics at the Central Institute of Stockholm (Wicksteed, 1948). Other pioneers included Johann Mezger of Amsterdam, Albert Hoffa and J.B. Zabludowski of Germany and Dr William Playfair in Great Britain (Taylor, 1988). By the 1890's massage was a popular craze among young ladies. Many claims were made for its effectiveness as can be seen from the advertisement in fig.1. However it also gained some unpleasant connotations when some brothels began describing themselves as massage establishments. The adverse publicity was such that the British Medical Journal of 14 July 1894 warned against the use of massage because of the unscrupulous people practising it.
Fig. 41.—From a photograph. Shows the condition of the patient before Dr. Playfair began to treat him with massage.

Fig. 42.—From a photograph. Shows the patient's condition after eight weeks of massage and feeding.

The article claimed that although some of the practitioners had certificates of training given to them by physicians many were given after "the most perfunctory course of instruction". The writer said that many of the certificates were, in fact, little more than "a recognition of prostitution" (p.88). To counteract this, in 1894, four nurses, (Lucy Robinson, Rosalind Paget, Annie Manley and Margaret Palmer) who had been trained in the art of massage founded the "Society of Massage". Their aim was to protect the good name and therapeutic value of massage at a time when it was open to misuse and misinterpretation. It was imperative to these founders that they should act "under doctors orders" and with doctors patronage in order to maintain their respectability. They wanted to make massage a "safe, clean and honourable profession for British women" (Wicksteed, 1948, p. 26). Consequently they pledged to only carry out treatment under medical direction. This trade of professional autonomy for the support and respectability of the medical profession also involved the emerging profession "accepting both the medical model of disease and a subordinate role" (Parry, 1991, p. 435).

Another reason for trading professional autonomy for the respectability offered by the medical profession was that by the late nineteenth century medicine was an organised, male dominated and centralised profession. The medical profession had already established itself and its monopoly and was so able to control the growth of other professions around it. These other health care professions were faced with either submitting to its dominance or else risking exclusion from mainstream practice, resulting in loss of respectability and power (Roberts, 1994). Physiotherapy, on the other hand, was, and is, a predominantly female profession. At least one writer (Short, 1986) claims that, not only did physiotherapy develop as a profession for middle class women, but that it continues today to recruit women from these backgrounds.

Following the first examinations held in 1895 in which seven candidates were awarded certificates, the founders sent circulars to medical practitioners and matrons of hospitals and nursing homes, advertising their services.
The society of trained Masseuses has been formed for the purpose of improving the training of, and organising an independent examination for, competent masseuses. It is hoped that this may establish a more uniform standard of proficiency and qualification. (Wicksteed, 1948, p.35)

The new profession continued to grow and had some 250 members by 1900. The term "physiotherapy" was first used in a notice in the British Medical Journal on 15 July 1905 which was advertising the First International Congress of Physiotherapy to be held at Liege in August of that year. One of the topics for discussion at the congress was to be "the indication of suitable means for the vigorous repression of quackery and the abuses caused by 'healers' who pretend to treat by physiotherapeutic procedures" (p.126). It is interesting that even at this early stage practitioners were jealously guarding that which was seen as their particular area of knowledge. By this time the scope of practice had broadened and physiotherapy was described as involving "electrotherapy, kinesthesy, the light treatment, the x rays, heat, aerotherapy, hydrotherapy, electro diagnosis, radiotherapy etc." (p.126). Its popularity grew still further with the demands placed on it by servicemen returning from the First World War. In 1916 Her Majesty the Queen became the Patroness of the Society- a definite step towards public recognition. In 1920 a Royal Charter was given to the Society by King George V. The Society was renamed the Chartered Society of Massage and Remedial Gymnastics and the central core of physiotherapy was defined as incorporating the skills of massage, remedial gymnastics and electro therapy.

In Australia the Australasian Massage Association was established in 1906 and a formal training scheme established. By the following year there were 302 members including seven from New Zealand. It was 1913 before training in massage was available in New Zealand and on 22 January 1913 the Senate of the University of New Zealand resolved "that owing to the importance of massage in the treatment of certain diseases the Senate would approve of the Otago University granting certificates for proficiency in massage" (Taylor, 1988, p.5).
In the period between the two wars the main area of work was the treatment of patients with poliomyelitis as epidemic followed epidemic (Forster, 1975). There was also an increasing emphasis on the treatment of injuries, the beginnings of treatment for asthma and the provision of ante and postnatal classes. Again, though, it was a war which provided new challenges, and during the Second World War physiotherapists began to be involved in the areas of orthopaedics and rehabilitation. With the introduction of the Salk vaccine for poliomyelitis in 1954, and the consequent decrease in the number of patients with the disease, there was a gradual transition to treating patients with neurological conditions.

The system of medical referral continued around the world and was endorsed in Britain when the ethical byelaws of the society were revised in 1928. Practitioners were not to undertake to treat any person except under the direction of a registered medical practitioner (Robinson, 1994). However, even though medical dominance was established it was not without its critics even in those early days. In 1928 and 1929 in a series of correspondence in the Journal of the Incorporated Society of Trained Masseuses practitioners complained that doctors were not referring patients to them, that they were doing their own treatments, especially electrical treatments, and that they were even employing their own masseuses who did not have the society’s qualifications. Most doctors argued strongly for the maintenance of the prescriptive role, one even hinting at the "dire consequences" if masseuses were allowed to diagnose for themselves (Robinson, 1994).

Medical dominance continued with the appointment of a doctor, Sir Cooper Perry, as the first chairperson of the British society in 1920 - a practice that continued for 50 years. It was 1972 before a physiotherapist was elected chairperson. Many writers (Miles Tapping, 1985; Parry, 1991; Pratt, 1989; Roberts, 1994; Robinson, 1994) claim that doctors were thus able to subordinate the emerging profession, which could have posed a threat to their dominance of health care. They were also able, more significantly, to dominate its theory. This, claims Robinson, has led to the moulding of physiotherapy practice to meet the needs of the medical profession. Parry goes further and states that in accepting doctors patronage the founders "accepted for present day
physiotherapists both the medical model of disease and a subordinate role which
colours their view of themselves, their practice, their knowledge and legitimate ways of
obtaining knowledge" (p. 169). However Wicksteed (1948) says that when considering
the wisdom of turning to another profession for help, two things have to be borne in
mind;

1) The long and arduous struggle for recognition as a professional body working
in close co-operation with the medical profession, which made essential the help
of that profession; 2) the lack of interest in the organisation and administration
of their own profession shown by the majority of members (p. 169).

In Great Britain in 1943, after over 20 years of discussion, the society decided to
change its name to the Chartered Society of Physiotherapy (CSP) as this was
considered to be more representative of the field of work that it covered (Edwards,
1987). The name had been similarly changed in Australia in 1939 to the Australian
Physiotherapy Association (APA) (Forster, 1975).

**The question of referral**

As we have seen, although questions were raised in the early days about the role of the
doctor in the prescription of physiotherapy, it was not until the late 1960's and early
1970's that the disquiet over physician referral became more widespread. The
publication in 1962 of the British Ministry of Health publication HM(62)18 caused
both rage and derision among physiotherapists (Lane, 1992). The document suggested
that:

Doctors should prescribe physiotherapy with the same precise therapeutic
indications in mind as they have when prescribing drugs and the dose should be
adequate to achieve the desired affect in the shortest possible time…All too
often therapy is prescribed in general terms and the important details such as
frequency and progression of treatment ... are left to the discretion of the physiotherapist. (HM (62) 18, Physiotherapy in hospitals. Para II (iii)).

This limited physiotherapists to carrying out the prescription dictated by the doctor without being able to exercise discretion or make a specialised assessment. The use of theoretical knowledge in everyday clinical practice - one of the central characteristics of a profession - was also restricted. This document led to referrals such as the following quoted by Rosemary Barnitt (1996): "the patient should rotate the right wrist clockwise and then anticlockwise, ten circumlocutions, ten times daily" (p.22). Physiotherapists practising at that time will be able to remember similar referrals from the mid 1970's which asked for ultra sound for six weeks or short wave diathermy three times a week for twenty minutes. There was little room for discretion if the patient improved or deteriorated before the stated treatment duration had elapsed.

By the mid 1970's it was becoming increasingly clear that doctors did not have enough knowledge about physiotherapy to make treatment decisions. It was pointed out by several writers (Dennis, 1987; Galley, 1975 & 1976) that the knowledge base of physiotherapy had expanded so rapidly, evaluation techniques changed, and treatment skills grown to such an extent that doctors were now poorly informed about treatment options and would have "limited skills in the diagnosis of movement dysfunction" (Dennis 1987, p. 181). Galley (1975) stated:

By not taking a more independent stance, we are failing, as a profession, in our moral obligation to the public. We fail because, by default, we are not giving the full benefit of our professional expertise to as wide a section of the community as possible. (p. 98)

It was clear that physiotherapy services were being wasted as a result of inappropriate referrals and in practice many referrals just stated "physiotherapy please". Direct referral was seen as benefiting the public in making a valuable service more accessible to them. Another strong reason for getting rid of the system of medical referral seems to have been the threat that some physiotherapists perceived from chiropractors and
osteopaths. Physiotherapists could see "their" patients making use of alternative practitioners because of easier access (Galley, 1976). In reviewing their syllabus and examinations in the early 1970's the CSP confirmed that the professional responsibility of the physiotherapist, after referral, was to ensure that patients were treated safely and effectively and so physiotherapists needed to assess patients for themselves. The new British syllabus came into operation in 1976 and since that time all physiotherapists have been trained to assess patients and make their own treatment decisions (Williams, 1983b).

In 1976 the British Chartered Society of Physiotherapists amended the rule that physiotherapists should only treat patients who had been referred by a registered medical or dental practitioner and this change became effective in June 1978. Changes were made in Australia by the Federal Council of the Australian Physiotherapy Association in 1976 and it was resolved that "a member may act as a first contact practitioner". In 1978 the annual general meeting of the Canadian Physiotherapy Association also removed compulsory referral from its Code of Ethics. As a result of this change a scathing article appeared in The Canadian Medical Association Journal in March 1979. The writer, Dr David Blair, described the medical profession as "deeply and reasonably concerned" about this departure from medical referral. He decries programmes of physiotherapy and occupational therapy education that have no medical input into the curriculum and where there is no "medical evaluation of the graduating personnel"(p. 159). He claims that physiotherapists will assume roles that are beyond their competence. He says that he cannot support patient management by allied health groups who do not have the endorsement in their treatments and evaluations of the more highly trained medical professionals. He concludes by saying that "physiotherapists who have a code of ethics that allows them to be independent of the medical model and function can only contribute in the long term to a decrease in the quality of patient care" (p. 520). These comments seem to support the view of those writers who claimed that in granting physiotherapists their patronage in the early days of the profession the medical profession was able to keep physiotherapy in a subordinate role.
Despite comments such as those made by Dr Blair the issue was discussed at the World Congress of Physiotherapy (WCPT) in 1978 and the WCPT Code was subsequently modified to give member organisations the freedom to remove compulsory referral clauses from their Codes and yet still retain membership of the WCPT (Teager, 1983). There were changes too in the United States of America and by 1986 about half of the States had passed laws to allow independent patient evaluation and treatment without medical referral (Purtilo, 1986).

However even though this fundamental change had occurred there were still many therapists for whom things continued much as before. Writing in 1985 in Canada, Carole Miles-Tapping said that physiotherapists were still in a dominated position. She described the position as follows: "Physiotherapists take referrals from doctors, but do not give orders to doctors. In the sense that doctors refer patients to physiotherapists and physiotherapists report the results of treatment to doctors, doctors evaluate the therapists" (p.290).

Some ten years previously Helen Hislop presented the tenth Mary McMillan lecture in the United States. She described physiotherapy as having an identity crisis in which it had lost its sense of identity and its cohesion. She made an impassioned plea for her dream to be realised and for physiotherapy to achieve "greatness as a profession". She saw the key to survival as being maintenance of the balance between science and humanity: "Physical therapy is the reasoned application of science to warm and needing human beings. Or it is nothing" (Hislop, 175, p. 1071). In Great Britain Julius Sim (1985) also accepted that some physiotherapists were still accepting prescriptive referrals from doctors and he says that in so doing they are presumably regarding the doctors knowledge of physiotherapy as "superior". This identity crisis is further explored by Joyce Williams in 1986 when she says that not only do newly qualified physiotherapists have trouble defining physiotherapy so too do superintendents and seniors. She claims that the physiotherapy image was simple once - the founders knew exactly what image they wanted to portray but this was no longer the case. She said, "physiotherapists are concerned that there is no easy explanation. They are often faced with a public that does not understand what they do and they frequently feel that their
medical colleagues do not always understand either" (p. 67). She also accepted that in some areas of Great Britain prescriptive referral by doctors was still occurring and she states that, six years after the changes had been made to the referral system, this situation "can no longer be considered appropriate" (Williams, 1983a, p. 435). The issue was raised again in the World Congress in 1987 when the claim was made that "not all physiotherapists are seen as having made the transition from technician to professional" (Valentine, 1989, p. 11).

The issue of professionalisation

The issue of the professional status of physiotherapy has received extensive coverage in the literature. Indeed, one of the stated aims of the founders of physiotherapy was to improve the professional position of women taking up physiotherapy.

The term "health professional" is one used to include a variety of occupations engaged in the delivery of health care. Most of them are eager to be called fully-fledged professionals. But what does this constitute? There is some general agreement about the hallmarks of a profession (Mercer, 1980; Sim, 1985; Thompson, 1979; Williams, 1986).

These are:

a) Selective entry - The professions seek to restrict the numbers entering the profession and set the entry standards. The training period is often lengthy and is university based. Young graduates often experience initial hardship but expect greater remuneration later.

b) Knowledge base - To be accepted as a profession most writers stress the need to have a substantial corpus of theoretical knowledge. This knowledge is particular to the group concerned.
c) Undisputed expertise - Professionals are the experts and the final arbiters in their particular field. Much of their power derives from this.

d) Autonomy - A profession controls its own practice and has full autonomy of action. It deals with its own complaints and disciplines its own members.

e) Provision of service - The professional provides a service that is intrinsically valuable and recognised as such by society.

f) Ethical standards - The power and autonomy of practice place the professional under a strong ethical responsibility to the client. Consequently it is claimed that the development of a code of ethics is one of the credentials of a group claiming to be a profession. Occupational groups aspiring to professional status have historically made one of their foremost concerns the development of a code of ethics. The development of a code becomes one of the external hallmarks testifying to the claim that the group recognises an obligation to society that transcends economic interest. This obligation is incurred in exchange for the power to regulate itself and to define requirements for membership in the profession (Sim, 1985).

In short, Glazer (1974) quotes Professor Everett Hughes, as saying, "Professions profess. They profess to know better than others the nature of certain matters, and to know better than their clients what ails them or their affairs" (p.347).

There are other, less well established, criteria including the tendency to independent practice and the existence of a professional association. The traditional professions also tend to be male dominated.

**Physiotherapy as a profession**

Physiotherapy is classed by the Registrar General in the United Kingdom as a lesser profession along with teachers, police officers, nurses, dieticians, radiographers and
occupational therapists. It comes behind the fully-fledged professions of doctors, lawyers, architects, dentists, pharmacists, opticians and the clergy. Glazer (1974) calls law and medicine the major professions and classes everything else as a minor profession. It has been claimed that the professions are distinguished from the occupations of business, trades and crafts in that the former are ruled by the ethic of self-sacrifice and the latter by the ethos or ethic of the market place (Pellegrino, 1983).

How does physiotherapy match up to these proposed hallmarks of a profession? There are certainly strict entry criteria in most parts of the world. Most countries, including New Zealand, have extended training to four years, training is now university based and there is an increasing number of opportunities for postgraduate education.

In physiotherapy worldwide there is an enlarging and strengthening knowledge base resulting from these increased educational opportunities. However much of this knowledge base is drawn from science and has come to physiotherapy via medicine. It is embedded in the medical model. Tyni-Lenne (1989) goes so far as to say that there is no general knowledge base peculiar to physiotherapy. He says "since there is no general knowledge base in physiotherapy, each of us, when describing what physiotherapy is, expresses different aspects of the physiotherapy paradigm, depending on what we value and are conscious of in physiotherapy" (p. 169). Krebbs and Harris (1988) also hold this view. Williams (1986), however, disagrees and says that physiotherapy can base its knowledge on its historical roots of massage (which has led to the modern use of manipulation and manual therapy), medical gymnastics (which has given rise to the skills of observation and the biomechanical analysis of movement) and medical electricity which has led to observation of the placebo effect and psychological dimension of treatment. She claims that this constitutes a knowledge base that places physiotherapy apart from other professions.

Attempts have been made to redefine the paradigm of physiotherapy in a quest for autonomy (Bassett, 1995; Parry, 1991; Pratt, 1989). In one such example Bassett argues for a modified biopsychosocial model for physiotherapy. She gives a coherent explanation of physiotherapy which she claims can be used in New Zealand:
Physiotherapy is an orthodox medicine profession that assesses, treats and educates individuals who have problems with function and mobility utilising manual and movement therapies, and medical electricity. These methods are based on physical and physiological principles, and are known to affect the individual physically, psychologically and spiritually. Using the clinical reasoning process methods are selected so that they are suitable for the individual needs, and are applied in a manner which is both culturally sensitive and gender appropriate for the individual, taking into account their social environment. (p.10)

Physiotherapists claim to have undisputed expertise in the treatment of function and movement disorders. Jackson (1987) says that they have undisputed expertise in the areas of manipulative medicine, pain control and the rehabilitation of neurological patients. Mercer (1980) also claims that in some areas the physiotherapist has undisputed expertise. He gives the example of the intensive care unit and says that in this setting the physiotherapist shares with the anaesthetist "life and death" responsibility for the patient. "If the doctor is God", he says, "the physiotherapist is archangel. Nowhere else in physiotherapy is this ultimate in professional responsibility to be found" (p. 182). It has been proposed that the reason why physiotherapist's expertise is disputed in other areas is because of insufficient research (Valentine, 1989).

Clinical autonomy for physiotherapists exists in New Zealand and in most other parts of the world. But again the assertion is that this is not true autonomy because the physiotherapist is firmly based within the medical model. In much of the literature it is recognised that autonomy and freedom from medical dominance is not just a question of being free to act as first contact practitioners. Rather medical dominance will continue while there is medical control over the legitimacy of ideas and information and the power to define what is scientific and what is quackery (Miles-Tapping, 1985). The medical profession also has control, either direct or indirect, over most of the institutions where physiotherapists work. Physiotherapists get caught in a trap not of their own making. Through experience they know that certain approaches work but
they are often unable to prove it scientifically, at least according to the laws of evidence imposed by the dominant class. Doctors often have the same problems but because of their dominant position they are less often asked to justify their assertions:

Under pressure from budget limitations, physiotherapists often launch studies to "prove" that accepted therapies work. Confounded by small sample sizes, placebo effects and the multitude of variables which may have an effect but which are impossible to control, such studies often show statistically insignificant findings. (Miles-Tapping, 1985, p.292)

Basset (1995) says that it is time for the profession to start to analyse what it is that it does, and use this as a basis for establishing a theoretical framework suitable in which to locate physiotherapy.

This lack of a clear understanding of what physiotherapy is could be a major stumbling block to achieving full professional status. It has been suggested that for a group to become a profession it must have power and for a profession to gain power it must project a strong and clear image of itself to the public. "Winning power is the essence of becoming an independent, rather than a subordinate profession" (Miles-Tapping, Rennie, Duffy, Rooke & Holstein, 1992, p. 290). Further, it is argued that professionalisation is not just to do with acquiring the trappings of professionalism but more to do with issues of power, control, social structure and systemic exploitation (Kermode, 1993). Authority will be demonstrated by the ability to define the problems which are uniquely the domain of physiotherapy and which the community will accept as uniquely the domain of physiotherapy. It is further demonstrated by the ability to effectively treat or deal with these problems and the ability to determine the point at which the service should be initiated or terminated. This latter point poses problems for physiotherapists as the current Accident Compensation Corporation (ACC) regulations control access to treatment and the time span of treatment. While the occupation of physiotherapy has approached the status, working conditions and self-image of a profession it still lacks the true social power that defines the older professions of law
and medicine. One of physiotherapy's problems is its small size. Small may be beautiful but power and influence often correlate with size.

Another of the criteria of a profession is that it has a well-developed code of ethics. The first written Code of Professional Practice was published in Great Britain as long ago as 1936 and it remained largely unchanged until the mid 1980's. Changes were then needed in response to changes in referral practice. The first ethical committee was set up in 1981 and a new Code of Conduct was published in 1985 and "additions and amendments" were made in 1995. In New Zealand Rules of the Society of Physiotherapy were produced in 1950, 1971, 1978, 1984, 1985 and 1988. However it was not until 1989 that a paper entitled "Ethical obligations of physiotherapists" was produced and sent to all members. However, despite the existence of these Codes, ethical understanding and application to the practice of physiotherapy is still in its infancy. Lynley Katavich, a lecturer in the Auckland School of Physiotherapy writes, "development of the ability to make ethical decisions is an essential component of professional growth. Without ethical decision-making the treatment decisions made by physiotherapists have the potential to jeopardise the advancement of the profession" (p.12). Bamitt (1993), in Britain, further comments that although the majority of physiotherapists know that ethics is about life and death issues such as euthanasia and abortion few have any understanding of ethics as a day to day event which impinges on their clinical practice. She insists that further discussion about ethical issues in physiotherapy is urgently needed.

Physiotherapy training in New Zealand has recently moved from a three-year diploma course to a four-year university degree course. Initially the government refused to subsidise students in their fourth year of training. However this decision has recently been changed. If the granting of a Royal Charter to the British Physiotherapy Society was seen as evidence of public acceptance there then perhaps government funding of the fourth year of training can be interpreted in the same way in New Zealand.

The fact that professions are typically male dominated poses a problem for physiotherapy in that it is largely a female profession. Professionals have traditionally
been characterised by the commitment they have to their profession. This commitment is necessarily decreased in the predominantly female professions because women are still largely responsible for child rearing, caring for aged parents and providing the major components of domestic work. They are therefore less able to make a commitment to their profession and they are also likely to have to take career breaks. A Canadian career study of physiotherapists by Gelmon and Williams (1983) showed that males hold a privileged position, even within traditionally female occupations. They tend to have stronger career orientation, take fewer breaks, and change jobs for reasons of advancement. They are disproportionately represented in managerial, academic and professional positions in physiotherapy. Rather than the increasing entry of men into physiotherapy resulting in an improvement in the position of women the reverse has perhaps been true. There is an increasing trend for men to own private practices and for women to be employed by them, frequently on a part time basis.

The development of the profession under the medical umbrella, the continuation of the ACC acting as gate keepers to who should have physiotherapy, the predominance of females and small size are all acting as barriers to the recognition of full professional status. Physiotherapists may see themselves as full professionals but others do not. Sim (1985) sums up the situation by saying that physiotherapy is moving towards full professional status.

Professionalisation in nursing, midwifery and occupational therapy

It is interesting to compare the professionalisation process in physiotherapy with that in the other health occupations with which it is most commonly linked. Nursing has a similar history to that of physiotherapy in that it developed under the medical model and the founders sought medical patronage in order to grow. Midwifery is somewhat different in that midwives used to be autonomous practitioners but then midwifery became medicalised and was regarded as a branch of nursing. The recent introduction of three-year degree courses for midwives without the need for initial nursing training may do something to restore their autonomy. Occupational therapy, on the other hand,
had, at the turn of the century, a specialised body of knowledge based around the concept of human occupation (Kielhofner & Burke, 1983). However, as medicine became increasingly shaped by reductionist thought, the biomechanical sciences and analytic science replaced the humanistic science in occupational therapy.

There is a lot of talk about professionalism in the nursing literature, but as Katz (1969) reminds us "few professionals talk as much about being professionals as those whose professionalism is in doubt" (in Sim, 1985, p.14). In the literature of all three professions there is extensive discussion of the need to define a specialised area of knowledge (Bellner, 1996; Bradshaw & Bradshaw, 1997; Jongbloed, 1984; Keogh, 1997; Ohlen, & Segesten, 1993). One problem, particularly in nursing and midwifery, is that new tasks delegated to practitioners have usually been innovated and tested by physicians and then passed on once they have been declared routine. Many midwives and nurses see their increased role as progress but in reality it further demonstrates the professional power and dominance of physicians. Carter (1994) calls for nurses to "expand" rather than "extend" their roles. "The former", she says, "involves the monopoly of an area of work and contrasts with the latter which involves following the medical hierarchy and carrying out tasks which the medical profession no longer wish to perform" (p. 370).

**Professionalism and body of knowledge**

As already discussed there is a lot of emphasis on the possession of a specialised and unique body of knowledge. However, this may be an elusive concept, for, "what occupational group can claim that its body of knowledge needs no further development? What body of knowledge - theoretical or otherwise - has achieved the perfection implied by the notion of complete professionalisation?" (Winter, 1988, in Kermode, 1993, p.106). Further it might be noted that much of the knowledge base employed in the practice of medicine is borrowed from sciences such as anatomy and biochemistry. This suggests that possession of a unique body of knowledge is not a necessary condition for the attainment of professional status.
It is difficult for both occupational therapists and physiotherapists to prove that there is no substitute for some of their work. There is some overlap with each other and also with other health care providers. Belanger (1997) holds that physiotherapists, if they aspire to increased power and professional status, must be careful to limit their field of practice to physiotherapy. Clients, and the general public, must be able to identify the registered physiotherapist and know what expertise to expect from them. "There must be a clear and visible distinction between a physiotherapist and an acupuncturist; between a physiotherapist and an osteopath or between us and any other professional close to our field of practice" (p.165). As previously discussed therapists lack power to legally restrict others from performing their services. Others may perform the services of a physiotherapist or an occupational therapist so long as they do not call what they are doing physiotherapy or occupational therapy. For example, in physiotherapy practice at the moment, it is proving difficult to protect the term "therapeutic massage" even though physiotherapists are the only members of society licensed to perform therapeutic massage. In a study in 1996 Bellner claimed that professional status depends on three things - the ability to monopolise access to valued skills and knowledge, the legislative protection of the profession and a demand for these skills by society. Status depends on the success with which therapists convince members of society that their work is irreplaceable and, on the other hand, on society's willingness to offer professional status to the therapists.

Both physiotherapists and occupational therapists have particular difficulty in convincing society that their knowledge and technologies are unique and that there are no substitutes for the services they offer. The epistemology of practice, with the source of knowledge embedded in the routines of everyday action, might be an obstacle to monopolising an important function (Bellner, 1996). For example it would be difficult to suggest that only a physiotherapist has sufficient knowledge to teach a patient to walk or that only an occupational therapist has the requisite training to teach a patient to feed or dress herself.
However, despite the traditional reliance on the possession of a specialised body of knowledge as a mark of professionalism, one might ask how important this really is as we prepare for the next century. In today's world there has been a narrowing of the knowledge and competence gap between the professional expert and the lay public as a result of increased education standards and the dissemination of knowledge by the media and the Internet (Parkin, 1995). Patients challenge the experts as a matter of course rather than as an exception. While most definitions of the term "profession" include the possession of a "unique and specialised body of knowledge that is used in service to society" the notion that medical, or any other knowledge, is exclusive, is open to challenge. Because of the Internet many individuals now have access to a variety of worldwide sources of information, including medical databases and full texts of medical and health related journal articles. While the fact that others can have access to medical knowledge in this way does not threaten its status as medical knowledge it does highlight the question of what it really means to have professional knowledge in today's world. Professional knowledge needs to be reinterpreted as "clinical judgement" rather than knowledge per se. There needs to be an emphasis on the appropriate clinical use of information. This will involve the physiotherapist acquiring a greater knowledge and understanding of the individual patient and in carefully monitoring the patient's unique responses to treatment. The professional's knowledge, combined with critical thinking and clinical judgement will enable them to transform information into meaning which is significant to the individual patient (Eisenhauer, 1998). Education, therefore, should be based on accessing and using information, on developing the skills of critical thinking and the critical analysis of information. The uniqueness of physiotherapy 's knowledge base should be to do with its own particular way of thinking about the nature of a given situation and the way in which knowledge is applied. The physiotherapist needs to be able to use his or her own professional ability to understand the individual patient and the way in which that individual responds to treatment. Professional knowledge is no longer just facts or information but rather the application of knowledge through the use of critical thinking skills in clinical judgement that results from a thorough understanding of the particular patient (Eisenhauer, 1998).
Pellegrino (1983) says that rather than attaching importance to the possession of a specialised body of knowledge, the crucial element that marks a profession is the special kind of interpersonal relationship that exists between its members and their patients. The true profession deals with people in "special existential states of vulnerability in which there is some wounding of the very humanity of the person in need" (p. 172). The needs the professional addresses are of a personal nature and involve patients revealing confidential and sometimes-intimate aspects of their lives. Physiotherapy seems to fit very well within these criteria.

**Does being a member of a profession really matter?**

Whether or not physiotherapists, occupational therapists and nurses are moving towards professionalism we need to ask if this is really such a desirable state. Green (1991) says that we need to acknowledge that "professionalism is not the only way to go" (p. 55). The quest for professionalism often has more to do with the quest for self-esteem in relation to other occupational groups than with the standards of patient care. As Pellegrino (1983) states scathingly:

> Professionalism and professionalisation may serve socially useful goals if they improve standards of performance or inculcate a sense of pride and morale. Less admirably, they may simply be steps to higher social status and more pay or simply a way to maintain an exclusionary monopoly of education and practice. Professionalism and professionalisation then became self-serving ideologies and ends in themselves. (p. 172)

Both Bruhn (1987) and Zimmermann (1974) agree, claiming that the patient or client is often the loser in attempts to protect professional boundaries. Care becomes fragmented, costs rise, and patients receive conflicting advice.

It is also interesting that nursing, occupational therapy and physiotherapy are seeking to professionalise at a time when the professions are under increasing scrutiny and
criticism. Some claim that the professions as a whole are in the middle of a crisis of confidence and legitimacy and have failed to live up to the ideals that they set for themselves. Their major task must now be to restore their moral credibility (Pellegrino, 1983; Schon, 1983). There is criticism too from female writers such as Short (1986) and Griffin (1990) who claim that the traditional definitions of a profession have an androcentric bias. Short states that "professionalisation is a masculine strategy in a patriarchal society" (p242). If it is true that women are treated badly by the established professions it is ironic that the female dominated occupations of physiotherapy, occupational therapy and nursing see professional status as desirable.

It could also be said that professionalism is not a good thing from the perspective of the client as it involves health care providers placing themselves as exclusive experts. Although this generally works for the benefit of the individual patient there have been several examples around the world, and also at National Women's Hospital in New Zealand, where this had detrimental effects. Campbell (1989) says that one of the reasons why well-meaning health care professionals have so much difficulty in treating their patients as self-determining adults is partly the fault of the ethos of professionalisation with its stress on the health care professional as expert. In fact Williams (1992) cites medicine, occupational therapy and physiotherapy as professional groups who effectively subordinate their clientele through defining the client’s problems within a paradigm which furthers the interests of the professional rather than the clients. The professional, in setting him or herself up as an expert in a given area can also become isolated and insulated, making communication with the public and other health care professionals more difficult.

Zimmerman (1974) describes yet another negative effect of professionalisation. He says that the most destructive impact of professionalisation is its "dehumanising effect upon students and health practitioners" as the process of becoming a professional all too often results in a loss of personal identity, openness and spontaneity as the individual becomes "submerged beneath a professional façade" (p.467).
General Practitioner although most doctors simply request that the therapist "assess and treat as appropriate". The editor of the New Zealand Journal of Physiotherapy says that this seems to indicate that "societies' health and illness institutions still favour the opinion of the medical profession in matters relating to physiotherapy" (Bassett, 1996, p.4).
Chapter 2: Ethical issues in physiotherapy

Little is known about the ethical dilemmas that physiotherapists encounter in the course of their clinical practice. Also, medical ethics programs rarely focus on the problems faced by allied health professionals such as physiotherapists. If a search is made for references to ethical issues in the physiotherapy literature it is quickly apparent that there were very few articles prior to 1970. Those that were published were all in American journals and seemed to have more to do with appropriate professional behaviour and etiquette than with ethics. In North America one author, Ruth Purtilo, has dominated the literature on ethics and physiotherapy. Her first articles appeared in the mid 1970's, some ten years before similar articles in the United Kingdom. This may have been a response to the more litigious nature of practice there. Purtilo identified physiotherapists as professionals who were responsible for making ethical decisions and who also had a need to understand ethical principles involved in such decisions (1974, 1975, & 1979).


Although it is assumed that physiotherapists experience ethical dilemmas in the course of their professional practice there have been a few attempts to demonstrate that this is indeed the case. In 1980 Guccione reported the results of a survey that he conducted of 187 members of the American Physical Therapy Association. He gave members a list
of situations in which ethical problems might occur and asked them to identify the
frequency with which they occurred in their practice. Seven primary and eleven
secondary issues were identified. The primary issues were: 1) prioritising patients
2) discontinuing treatment for non compliance, 3) treating the terminally ill, 4) continuing
to give psychological support once physiotherapy goals have been reached, 5)
professional responsibility when client needs and aspirations conflict with those of the
family, 6) issues involving third party payers and 7) maintaining the patient’s
confidence in another health professional despite the personal opinion of the
physiotherapist. Guccione also reported that although respondents recognised that they
often had to make difficult decisions they probably did not identify the decision as one
of ethical choice. He warns that this is of concern because "failure to recognise that a
moral point of view is required is a first step toward unethical behaviour" (p.1271). He
says that one of his reasons for undertaking the survey was to identify issues of
professional ethics so that these could be discussed among physiotherapists and in the
physiotherapy literature. However, despite this aim, no follow up articles appeared in
the American journals.

In 1996 Herman Triezenberg in the United States used a Delphi study to try to identify
current ethical issues facing physiotherapists and also which issues were considered, by
his panel of experts, to be ethical issues which would face physiotherapists in the
future. Ten current ethical issues were identified as consensus choices and a further
three as near consensus. A further four issues were identified as likely future issues
giving a list of sixteen issues. Triezenberg divided these into categories. There were six
issues involving patient rights, five professional issues and five relating to business and
economic factors.

**Patient rights**

Issues in this category included the right to informed consent, confidentiality, sexual
and physical abuse, social characteristics, protection for patients in research and setting
personal boundaries within the professional relationship. Of these, the issue of informed
consent has been most widely explored in the physiotherapy literature (Banja & Wolf,
Triezenberg claims that the other issues have not been discussed in the physiotherapy literature. However, while it is true that there are not many articles in American publications it is not true of physiotherapy journals in general. In British and Australian journals truth telling was raised by Barnitt in 1994 and Sim in 1986, confidentiality by Sim in 1997, allocation of resources by Clawson in 1994, sexual contact between therapist and client by Weerakoon & O’Sullivan in 1998, Cullen, Davidson, & Guthrie in 1997a and 1997b and McComas, Kaplan & Giacomin in 1993 & 1995 (Physiotherapy Canada journal), and the treatment of patients with AIDS by Sim in 1997. Guccione also identified this issue in his survey in 1980. Sim (1997) and Sim and Purtlo (1991) explored the issue of treating all patients fairly despite social characteristics relative to the treatment of patients with AIDS. The author has failed to find any articles in the physiotherapy literature dealing with other ethical issues relevant to physiotherapists such as negotiating outcomes with patients or matters of patient dignity.

**Professional issues**

The five issues in this category dealt with the over utilisation of physiotherapy services, maintaining clinical competence, staff supervision issues, protecting the environment and whistle blowing. Guccione (1980) identified three of these issues in his survey but there has been little discussion of any of them. Banja discussed whistle blowing in 1985 and several authors have made passing reference for the need for physiotherapists to keep up to date with clinical changes. There has been no discussion of the ethical issues inherent in using patients in teaching situations. Another professional issue that has had some discussion in relation to the treatment of patients with AIDS is that of whether or not the physiotherapist can refuse to treat some types of patients (Sim & Purtlo, 1991).

**Business and economics**

Into this section come issues to do with billing patients, advertising, endorsement of equipment, fraud in billing and exploitative business relationships. None of these issues
has been dealt with from an ethical perspective in the literature despite the fact that some of these issues have been of concern to physiotherapists since their beginnings.

In summary, until recently there has been little or no research literature with regard to physiotherapists and ethical practice in Great Britain. Consequently between 1993 and 1996 Rosemary Bamitt conducted a series of studies aimed at identifying the ethical issues encountered by physiotherapists working in the National Health Service. She found that physiotherapists did encounter ethical dilemmas in their daily work. The most common work settings where problems occurred were primary care settings and the acute hospital. The common themes that emerged were to do with resource allocation, appropriateness and effectiveness of treatment, therapist rights and duties, the professional relationship, truth-telling and confidentiality (Bamitt, 1996).

Although a similar survey has not been carried out in New Zealand it is reasonable to expect that the problems faced here would be similar to those in Britain. One difference that might be expected would be a higher proportion of problems occurring in the primary care setting due to the larger numbers of physiotherapists in New Zealand who are either self-employed or who are employed in private practice.

The ethical issues around informed consent, truth telling and confidentiality will be discussed further in the rest of this chapter. The remaining issues, as identified by Bamitt, will be considered in Chapters four and five in relation to the Code of Health and Disability Services Consumer's Rights.
Chapter 2:1: Informed consent

As discussed previously the issue most often identified in surveys and discussed in the literature as of concern to the newly autonomous physiotherapy practitioner is that of informed consent. The physiotherapist must demonstrate competent understanding in this area. This is of particular importance in the context of health care today where roles and expectations are constantly changing (Retsas & Forrester, 1995). Physiotherapists have taken over some of the traditional diagnosis and prescriptive roles of the doctor and, because of recent health legislation, they are more directly accountable to their patients.

Consent, in the health care setting, is the procedure by which a patient agrees to accept a suggested treatment plan. In the past informed consent could have been defined as that consent obtained from a patient whose decision was based on the information provided to them by the health care professional. However, in the 1990's, patients obtain their information from many sources, not just from the health care professional. Public use of the Internet allows lay people to access a huge range of medical journals and other health care information. The role of the health care professional must now be to satisfy himself or herself that the patient's information is accurate and understood by the patient and to fill in any gaps. The issue of how much information is required, and who decides how much is sufficient, will be discussed later.

There have been many attempts to adequately define the term "informed consent" and various alternatives such as informed request and informed choice have been suggested. Raanan Gillon (1985a) defines it as a "voluntary, uncoerced decision, made by a sufficiently competent or autonomous person on the basis of adequate information and deliberation, to accept rather than reject some proposed course of action that will affect him or her" (p.1700). In the physiotherapy literature Sim (1986a) defines it as the "voluntary and revocable agreement of a competent individual to participate in a therapeutic or research procedure based on an adequate understanding of its nature,
purpose and implications" (p.584). Retsas and Forrester (1995) define an "ideal" consent as one in which "the patient has been given sufficient information concerning the nature of his or her condition, the nature of the proposed treatment or procedure, possible alternative treatments or procedures and the chances of success or failure of proposed or alternative treatments or procedures" (p.320). This definition includes the assertion that the information must be 'sufficient' without any explanation as to what constitutes sufficient information. This will be addressed later.

Informed consent is a relatively modem phenomenon. In the early seventies it was not uncommon to read statements in the medical literature like the following:

"Many of our patients are uninformable and we would never get through the day if we had to obtain their consent to every potentially harmful study" (Demy, 1971, p.696).

"Informed consent really is a nonsense. I've never had a patient refuse to have anything done that I've asked him. The patient can't understand what's at stake"(Eilenberg, 1973, p.224).

"The best and probably only guarantee of a patient or subject's rights is the integrity of his physician... Informed consent is a legalistic fiction that destroys good patient care and paralyses the conscientious physician" (Laforet, in Sim, 1986, p.584).

The legal history of informed consent

Faden and Beauchamp in their book "A History and Theory of Informed Consent" say that there are two opposing views about the existence of consent in the history of medicine. One view is that held by the historian Martin S. Pernick that "truth-telling and consent-seeking have long been part of an indigenous medical tradition, based on medical theories that taught that knowledge and autonomy had demonstrably beneficial effects on most patients' health" (p.56). By contrast the psychiatrist, Jay Katz, holds that
"the history of the physician patient relationship from ancient times to the present... bears testimony to physicians' inattention to their patients' right and need to make their own decisions" (p.56). Certainly, Hippocrates advised physicians to "conceal most things from the patient" and to "reveal nothing of the patient's future or present condition" (In Campbell, Charlesworth, Gillett & Jones, 1997).

It is often claimed that the first case about consent to treatment was the case of Slater v Baker and Stapleton in 1767 (860, 2Wils. K.B. 359(1767)). In this case the court stated that "indeed it is reasonable that a patient should be told what is about to be done to him, that he might take courage and put himself in such a situation as to undergo the operation".

One of the most well known opinions was given in 1914 in the legal case, Schloendorf v Society of New York Hospital, (211. N.Y. 125, 105, N.E. 92 (1914)) by Justice Benjamin Cardozo. In this case a patient consented to an investigation under anaesthetic, clearly stating that she didn't want surgery. However when a tumour was discovered during the investigation it was removed and the patient complained that this was done without her consent. Cardozo, J. upheld the view that patients have the right to self-determination and, if this right is violated, an unauthorised touching, or battery, has been committed regardless of whether the treatment was beneficial or not. He stated that "every human being of adult years and sound mind has the right to determine what shall be done with his own body; and a surgeon who performs an operation without his patients' consent commits an assault, for which he is liable in damages". It is the patient's consent that makes the touching legally innocuous. It was following this case that self-determination, or autonomy, came to be given more importance than beneficence in medical practice in the United States. Nevertheless in clinical practice the extent of disclosure continued to be influenced more by beneficence than by autonomy and no major legal changes were made for some years (Faden & Beauchamp, 1986).

In the physiotherapy situation the ruling of Judge Cardozo means that, if a patient presents, for example, with a painful shoulder and on examination the physiotherapist
discovers that the patient's shoulder pain seems to be pain referred to the shoulder as a result of a cervical spine problem the physiotherapist should not automatically proceed with a neck mobilisation. The physiotherapist must first discuss her findings with the patient, explain the situation and obtain consent for the proposed procedure. She cannot just assume that the patient wants the neck problem treated.

The term "informed consent" was first used in medicine related case law by Justice Bray of the California District Court in 1957 in Salgo v Leland Stanford Jr. University Board of Trustees (317 P.2d 649 [Cal Dist Ct App 1957]). Salgo suffered paralysis following surgery and claimed that he had not been warned of the risk. The court found that consent alone is not sufficient and that the doctor has a duty to disclose to the patient "any facts which are necessary to form the basis of an intelligent consent". Judge Bray claimed that this "new" duty to disclose risks and alternative treatments was a logical extension of the already established obligation to reveal the nature of the proposed treatment. This brought together the concept of self-determination with the concept of a positive obligation to warn the patient of possible harms and dangers.

Another landmark decision came in Natanson v Kline (354 P.2d 670 (1960)) in the Kansas Supreme Court. The patient had radiation therapy following a mastectomy for breast cancer and in consequence suffered radiation burns. This case established the patients right to refuse treatment even if the doctor believed the treatment to be in the patients best interest: "each man is considered to be master of his own body and he may, if he be of sound mind, expressly prohibit the performance of lifesaving surgery or other medical treatment". The case established that mere consent of the patient does not shield the physician from a negligence claim. The medical performance may have been flawless but if an injury results from a known risk that has been undisclosed then there may be liability (Faden & Beauchamp, 1986). The case also maintained the standard of disclosure as the professional standard, the information that any "reasonable medical practitioner" would disclose. The implication of these cases to the practice of physiotherapy is that the physiotherapist must disclose all known risks to the patient. When treating the patient with an ice pack, for example, the possibility of an ice burn should be discussed with the patient. However, it may not be necessary to disclose the
risk if one could show that a 'reasonable body' of other physiotherapists would not have mentioned the danger.

Three negligence decisions in the United States in 1972 came to be regarded as landmarks in that they began to change the standard of disclosure to the patient-centred "reasonable person standard". These were *Canterbury v Spence* (464 F.2d 772 (DC Circ.1972)), *Cobbs v Grant* (104 Cal Rptr 505 P.2d 1(1972), and *Wilkinson v Vesey* (295 A.2d 676 (R.I 1972)). *Canterbury v Spence* set the reasonable patient standard. In this case a patient with upper back pain was found, after a myelogram investigation, to have a defect at T4 and a laminectomy was recommended. The patient suffered paralysis after the surgery and the court held that it should be "the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie". This changes the physiotherapy scenario discussed above in that the physiotherapist should now disclose the danger of an ice burn even if his or her colleagues would not have done so. This is because the "reasonable" patient would probably want to be warned of this danger and, of course, a responsible practitioner would also want to ensure that they were aware of it.

However Faden and Beauchamp claim that despite these cases this change to the reasonable person standard remained a minority trend. The courts were swimming "upstream against a powerful current of support for this (the professional practice) standard" (p.137). The cases that changed the expectations concerning disclosure are discussed later.

As far as the law is concerned the patient must be provided with a description of the proposed treatment and its rationale, a description of any alternative treatments, including non-treatment, the risks and consequences of the proposed treatment and its alternatives and an indication of the prognosis. The law also recognises that there are some exceptions to the need for informed consent. These include: a) the patient will be exposed to serious harm or death if the intervention is not provided at once (the emergency exception), b) the patient voluntarily gives up all rights to be informed and asks the doctor to make the decisions (the waiver exception), c) the physician has good
reason to think that the information would cause the patient serious physical or psychological harm (the therapeutic privilege exception), and d) prior patient knowledge in which there is no need to disclose risks which are common knowledge such as post operative discomfort or things which the patient has experienced before (Brazell, 1997).

Only some of these are relevant in the physiotherapy setting. It is almost impossible to think of occasions when the emergency exception would apply as few procedures are ever carried out as an emergency. Equally the therapeutic privilege exception would rarely apply to the physiotherapist directly, as she is unlikely to be in possession of information that would cause the patient serious physical or psychological harm. If this does occur then it will be because the information has come to her via the physician or some other member of the health care team. The dilemma facing her would then be to do with truth telling and her professional relationship with the doctor rather than informed consent. Patients receiving physiotherapy do sometimes give up their right to be informed and ask the physiotherapist to make all the decisions about treatment without consulting them. As Edward said to his doctor in T.S.Elliott's “The Cocktail Party”:

I can no longer act for myself
Coming to see you - that's the last decision
I was capable of making. I am in your hands.
I cannot take any further responsibility. (p.100)

Thus the law recognises that such circumstances occur and absolves the health care professional from the duty to obtain informed consent to procedures. However the practitioner must be careful to ensure, in these situations, that the decision to forego consent is in itself an informed decision. Sometimes patients, especially the elderly, behave in this way, as they want to please the health care provider and avoid causing fuss or trouble. The point is also made that there is no need to disclose risks which are common knowledge or which the patient has experienced before. So the physiotherapist would not need to explain the risks associated with ultra sound treatment on every
occasion that the patient attends for a repeat treatment. Neither would she need to warn
the patient of the pain associated with the removal of adhesive strapping as this is
common knowledge, however, the conscientious practitioner would have discussed the
pain of removal with the patient before the strapping was applied.

**Problems with the legal understanding of informed consent**

Faden and Beauchamp claim that although "moral philosophers and other disciplines
joined the bandwagon and became contributing causes of change" by comparison the
courts "must be said to have been the pioneers of today's concerns about informed
consent"(p.143). However, Stephen Wear (1993) points out that a legal requirement is
not the same as an ethical requirement: "The law often tends to speak, at most, to what
one might see as minimally necessary, as opposed to ethically sufficient in a given
case" (p.19). The way in which law and ethics are interrelated will be discussed in
chapter five. What is the law interested in as far as patient informed consent is
concerned? Until recently complete lack of consent was actionable as battery but
inadequate consent was only actionable if injury resulted. Changes came about with the
introduction of the Code of Health and Disability Consumers' Rights and these changes
will be discussed later. There is no legal action possible for inadequate provision of
information *per se*. So it would appear that what the law is interested in is prevention
of harm and not with maintaining patient autonomy. Returning to the example of the
patient receiving treatment with an ice pack, if the treatment is given and the
physiotherapist does not warn the patient of the risk of an ice burn and if no burn occurs
the physiotherapist is not liable under the law. They would only be liable if a burn did
occur and the patient had not been warned of the possibility.

The law also assumes that people are capable of evaluating the risks and benefits of a
procedure if they are given adequate information. Its main concern is where there has
been inadequate information, coercion or manipulation. However, it is questionable
clinically, whether most patients are capable of the sophisticated reasoning necessary to
choose between the various options. Wear (1993) says that the law "rarely seems to
appreciate the basic assaults that illness can make on personal autonomy" (p.19). There are particular problems for physiotherapists working with patients with chronic or degenerative diseases in a rehabilitation setting. The question becomes one of how far autonomy should be respected when autonomy itself is compromised. The physiotherapist, particularly in the rehabilitation setting, is involved in the treatment of patients whose autonomy is compromised. Such patients include those who have had head injuries or a CVA, who, especially in the days immediately following the incident, are distressed and confused. They are unable to act autonomously as autonomy involves both autonomy of decision making and autonomy of action. Decision making ability may be impaired because of cognitive impairment and autonomy of action impaired because of physical disability. Even if the ability to make decisions is unaffected speech problems such as aphasia can make the communication of autonomous decisions very difficult.

The law, to date, has not considered any responsibilities that the patient may have. Faulder (1985) acknowledges that patients may have responsibilities when she says, "we must also accept that in claiming our right to be informed we too will have to shoulder new responsibilities because rights entail obligations, both on those who claim them and on those from whom they are claimed" (p.23). For the relationship between patient and health care provider to be equitable the patient needs to confide in the health care professional just as much as the health care professional confides in the patient. Fully embracing this autonomy-enhancing informed consent requires "perceptual shifts, not only among those who provide health care but also among those who receive it" (Coy, 1989, p.830). In 1994, predating the Code of Health and Disability Services Consumer's Rights by two years, the New Zealand Society of Physiotherapy produced a leaflet for patients entitled "Rights and responsibilities: Your rights and responsibilities as users of physiotherapy services". It lists patients' rights, which are very similar to those in the Code, but it also lists patients' responsibilities. It suggests that patients have a responsibility to be open and honest in response to physiotherapists' questions and to provide the physiotherapist with accurate information about their medical condition and history. It also states that patients should comply with the treatment by carrying out any home exercises prescribed by the physiotherapist. It is also stated that
they have a responsibility to be "attentive to personal hygiene" and to be considerate of the physiotherapist. The Codes of other professions have also paid a lot of attention to how patients should behave in the relationship. For example in the 1987 Code of the New Zealand Medical Association the proper behaviour of patients is seen as 'obedience' and the section on the 'obligations of patients' is longer than that on the 'duties of doctors'. The power imbalance between the parties was obviously accepted as an established fact. Although patient responsibilities do not feature in the Code in such a clear way patients are still required to accept responsibility for their autonomous decisions even if it turns out that the decision was not the 'correct' one in the light of the consequences. For example a physiotherapist, after discussing all the implications with a patient, may advise the patient that joint manipulation is likely to be the best treatment for their painful neck. The physiotherapist would also discuss other options such as heat and massage, which are likely to be less effective, but which carry fewer risks and are more pleasant for the patient. If the patient decides to try heat and massage in preference to the more risky, but more beneficial option of manipulation, then the patient cannot later blame the physiotherapist when their neck fails to improve as quickly as they desired.

The law then is concerned with the type of information that must be disclosed to the patient and that consent has been given. It is also concerned with whether or not the patient is competent to consent, an issue to be discussed later. However, from an ethical point of view there are other considerations.

The ethical justification for informed consent

Two different ethical principles have served as the moral foundation of the doctrine of informed consent: a) the principle of beneficence and b) the principle of autonomy (Beauchamp & Childress, 1994).

The principle of beneficence refers to a moral obligation to act for the benefit of others (Beauchamp & Childress, 1994). Autonomy is the capacity to think and decide and the
freedom to act on the basis of one's decision without restriction provided that other people's rights are not being violated (Gillon, 1985a). Further, the principle of respect for autonomy, is the requirement that we respect the autonomy of others.

These two principles can lead, however, to differing, and sometimes conflicting, understandings of informed consent. The principle of beneficence emphasises the importance of producing good outcomes and in the health care setting that usually refers to good medical outcomes. Working according to this principle would mean that health care professionals could proceed with treatment without a patient's consent and claim that they were acting beneficently. A well-known case where this argument was followed was that of Dax Cowart. Cowart was severely burnt in a propane gas explosion in 1973. Throughout his long hospitalisation he repeatedly demanded to be allowed to die. He refused all treatment and surgery, but, despite his being judged competent, neither his family nor his doctors would consent to his demands. The health care team continued to treat him in the belief that this was in his long-term best interest. As Childress and Campbell (1989) state, the fact that he is alive today and living a productive life, despite his blindness and other disabilities, "may be viewed as a triumph and vindication of medical paternalism over patient autonomy" (p.23).

However, when Dax was interviewed in 1996, some 23 years after the accident, he still maintained that "No, I'm not glad they forcibly treated me" (Cowart & Burt, 1998, p21). He claimed that the months of awful pain that he had endured were not sufficiently outweighed by the value of his current life (Arnold & Menzel, 1998). For Dax, as for many others, respect for autonomy is a principle that is highly valued and they find it unacceptable when it is overridden.

If informed consent is based on the principle of beneficence a patient's consent is needed in order to protect his or her interests and to ensure that good outcomes are produced. Therefore, if the intervention has no significant potential for harmful outcomes, informed consent will not be considered necessary because only good can result for the patient. The principle of autonomy on the other hand emphasises that, all other things being equal, competent adult patients always have the right to decide what will be done to them even if they choose a path which will lead to less good medical
outcomes. To be an autonomous individual and to have one’s autonomy respected implies that one must be allowed to make decisions for oneself, regardless of whether or not those decisions are regarded by others as being in one’s best interests. Joseph Raz (1979) is clear about this and says: "The purpose of rights is to develop and protect the autonomy of the agent. They entitle him to choose for himself rightly or wrongly. But they cannot do that unless they entitle him to choose wrongly" (p.267). The implication of basing the right to informed consent on the principle of respect for autonomy is that informed consent will be required, not only for procedures with potentially harmful consequences, but for all procedures even if the potential for harm is slight or non existent. This will then include all physiotherapy treatments, many of which are considered to be of low risk. When a physiotherapist treats a patient there is a moral duty to obtain that patient's informed consent, not because of risk of harm to the patient, or because of the threat of litigation, or because the physiotherapist is a first contact autonomous practitioner but rather because there is an ethical obligation to enhance patient autonomy. As autonomy enhancement is pursued informed consent becomes more than just a formal 'one-off' event and becomes more of an ongoing conversation between the patient and the health care provider. It changes the tone of the therapeutic relationship to one of mutual respect and equality and goes some way to addressing the power imbalance between the patient and the provider. As Coy (1989) states, "if autonomy enhancement is acknowledged as the moral foundation for informed consent, the necessity for obtaining informed consent for services is apparent" (p.830).

The elements of informed consent

Beauchamp and Childress identify seven components in informed consent. The first two - competence to understand and voluntariness in deciding- are identified as threshold elements or preconditions. The next three are to do with the information itself and are: disclosure of material information by the health professional, the recommendation of the health professional and comprehension, by the patient, of these two elements. Consent can then be given in that a plan is selected and then authorised.
Voluntariness, competence, information disclosure and comprehension will be discussed here. The recommendation of the health care provider and consent itself will be discussed in a later section.

i) Voluntariness

Patients have the right to make health care choices free from undue influence. Phenomena such as pain and fear, to which patients are subject, can compromise this freedom. It can also be compromised by external forces such as the use of force, either physical or through sedation, by coercion through the use of implied or explicit threats and by manipulation when there is deliberate distortion of the truth or omission of facts. Patients can also be influenced in more subtle ways because of the asymmetrical power relationship between the patient and the health care professional. Clinicians must also remember that patients can also experience pressure from other quarters such as from family, friends, employers, society and financial constraints. There may be a fine and subtle line between those influences which facilitate patient choice and those which are coercive.

Physiotherapists, as health care providers, must always bear in mind these other pressures which patients are subject to. This is especially relevant when dealing with the disabled or old who may feel the pressure of society's expectations which may prevent autonomy of action. An elderly woman who is in an acute orthopaedic ward following a fractured neck of femur may be anxious to return to her own home. However, she may become aware, from general conversations on the ward, that elderly people like her rarely return to independent living following a hip fracture. Her decision making may then be influenced by the expectations of others and she may be reluctant to articulate her choices. It can also be a problem in the rehabilitation setting where patients are treated by a wide range of health care professionals, all of whom may have differing views and expectations.
It is easy in physiotherapy settings to manipulate patients. Consider the following example:

**Case 1:**

The patient, an electrician, suffered 3rd degree burns in a work place accident. He is receiving physiotherapy treatment to prevent contractures in his skin grafts. Although cooperative with his exercise and stretching regime he is very reluctant to wear his counter pressure garments which he finds uncomfortable. The physiotherapist believes that the patient will eventually regret his decision not to wear the garments and tells the patient, knowing it to be untrue, that his insurance cover will be affected if he does not comply with all aspects of treatment.

This is a clear example of a physiotherapist distorting the truth in order to gain consent to treatment and, in the view of the physiotherapist, a better outcome for the patient. The physiotherapist is acting beneficently but overriding a competent patient's autonomy.

A further example shows that physiotherapists can also coerce a patient by the use of force, even though the force used is not physical force.

**Case 2:**

The patient is a seventy-year-old man with end stage chronic obstructive airways disease. He has been referred to physiotherapy for a respiratory assessment. When visited by the physiotherapist the patient says that he does not want physiotherapy as he is too tired and feels too unwell. He seems aware that his disease is terminal and expresses a desire to be left in peace. The physiotherapist, believing that she can help the patient, sets about explaining to him the advantages of the treatment and the consequences of his refusal. After some twenty minutes of "discussion", during which the physiotherapist becomes
increasingly agitated and the patient becomes increasingly breathless and
distressed the patient reluctantly, and for the sake of peace, agrees to treatment.

In this second case the physiotherapist does not distort the truth but the consent gained
still could not be described as voluntary. While physiotherapists may use persuasion
they must be aware that the boundary between persuasion and coercion is tenuous and
the patient's perception of what is occurring must be borne in mind. The boundary has
been crossed in this case. Although persuasion through discussion is to be encouraged
communication that is even mildly threatening must be avoided. The health care
professional also needs to bear in mind the fact that a patient's refusal of treatment, or
indeed their consent to treatment, may not be permanent. Patients frequently change
their minds about treatment if they are given time to consider and reflect. This is
particularly important in the physiotherapy setting where few interventions need to be
carried out as emergency procedures.

ii) Competence

This refers to the patient's ability to make a rational and autonomous decision. It
involves the ability to understand information, to appreciate one's situation, to weigh
risks and benefits and to have an understanding of the consequences of one's decisions.
In line with today's commitment to "main streaming" of the mentally and physically
disabled there is quite a low threshold for competence. Legislation such as the Mental
Health Act and the Protection of Personal and Property Rights Act assume competence.
Competence, however, cannot be understood as a uniform or global concept. Levels of
competence vary between individuals and may be affected by physical or mental illness
or by intellectual disability. Competency of individuals varies and might change though
time. A physiotherapist providing chest care for a patient following major surgery will
be aware that the level of competence and decision making ability displayed by the
patient in the Intensive Care Unit immediately following their surgery will be different
from that displayed by the same patient when they return to the general ward some days
later.
Even if the consumer has diminished competence some autonomous decisions may still be possible. A patient may well be competent to decide that he wants physiotherapy treatment in the morning, when his family can be present, rather than in the afternoon when he is tired and his family cannot be present but he may not be competent to decide which physiotherapy modality should be used. The danger for the health care professional is to assume that a patient is competent if they accept professional advice and incompetent if they don't. Faulder (1985) emphasises this point: "A patient's apparently irrational refusal of consent should never be taken as a sign of incompetence if, were it to have been given in the same circumstances, the consent would have been regarded as valid" (p.23). Nevertheless it remains true that a patient's capacity becomes a possible concern when she refuses a treatment which has been recommended by the health care professional and which is also accepted by the family. Another point to be considered is that impaired decision making capacity may not be permanent. An individual's decreased competence could be due to various reversible factors such as renal failure, medication interaction, confusion following surgery, the fluctuating nature of some forms of dementia, fever or post natal depression (Searight & Hubbard, 1998).

It can, however, be a difficult task to assess levels of competence. Indeed in several legal cases judgements have been altered as different judges have read the same facts and interpreted them differently. (See Re T: (Adult: refusal of treatment) [1993] Fam 95(Eng CA) and Re W: A minor (Medical treatment: Courts Jurisdiction) [Fam] 65 (Family Division)) In Re: T, Lord Donaldson MR said that the more serious the decision to be made the greater the capacity required. This applies equally to physiotherapy. The physiotherapist may well accept the decision of a patient with impaired competence to accept treatment with a heat pack but may require a different level of competence before treating the patient with short wave diathermy (SWD). This is partly for practical reasons - the patient compliance required for SWD is greater than that needed for a hot pack as the physiotherapist must rely on patient judgement and input - but it is also because the contraindications and dangers of treatment using SWD are more serious and need to be fully comprehended if a valid, informed consent, is to be given.
iii) Disclosure

This can take two forms - information that is volunteered by the health care professional and information that is given in response to the questions of the patient. Information given needs to include details of the contemplated procedure, any alternatives and the benefits and costs (including time, money, effort and risks) to the patient. Three different standards have historically been given for disclosure - the professional practice, or reasonable physician, standard, the reasonable, or objective, patient standard and the subjective patient standard. The professional practice standard maintains that adequate disclosure is determined by the customary practices of the particular professional community. This standard was upheld in the United States in *Natanson v Kline* (354 P2d 670 (1960)) in which the court held that the duty of the physician to disclose is limited to "those disclosures that a reasonable medical practitioner would make under the same or similar circumstances".

In England in *Bolam v Friern Hospital Management Committee* ([1957] 2 All ER 118, [1957] 1 WLR 582), an English case, the courts established that the professional practice standard was the acceptable standard of disclosure. In this case the patient suffered fractures as a result of having electro convulsive therapy without an anaesthetic. There were differences of opinion, in the medical profession, as to whether an anaesthetic should, or should not, have been used. The court found that "a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion", even though other doctors may adopt a different practice. This judgement maintains that information given to a patient remains a matter for medical judgement, and gave rise to what became known as the "Bolam principle".

The courts in England have generally retained this professional standard. It was tested in *Sidaway v Board of Governors of the Bethlem Royal Hospital* ([1984] QB 493, [1984] 1 All ER 1018 CR). In this case a majority of the House of Lords approved the *Bolam* test although several judges, including Lord Scarman, rejected it. It would seem
that their Lordships were convinced by arguments that enhancing patient autonomy would actually damage patients' health (Brazier, 1987). The Courts in England have also considered the degree of risk that they consider to be material. In *Sidaway* the patient suffered a complication that had a risk of less than 1% and the Court found that this was not a significant risk. Lord Scarman, in his dissenting opinion, defined materiality in terms of conditions to which a reasonable person in the patient's position would be likely to attach significance. In *Sidaway* a risk of 10% was agreed upon as material. This had previously been established in *Reibel v Hughes.* (1980) 114 DLR (3d) 1. In a recent survey in New Zealand it was found that patients wanted to be informed of a risk or around 1 in 1,000 or .1% (Newton-Howes, Bedford, Dobbs & Frizelle, 1998).

There are only two examples in English law where the expert medical evidence has been overturned. One was *Smith v Tunbridge Wells HA* ([1994] 5 Med LR 334, 339). In this case a body of experienced and competent surgeons agreed with the defendant that they would not have warned the patient of the risk of impotence following the surgery that he was about to undertake. However the judge regarded the omission as "neither reasonable nor responsible" and found the surgeon guilty of negligence. Interestingly, there is only one other clear example of a credible medical witness not being believed and this involved a physiotherapist. In *Clarke v Adams* ((1950) 94 SJ 599), the physiotherapist failed to warn the patient of the danger of being burnt in the course of treatment. He was found negligent even though an expert from the Chartered Society of Physiotherapists stated that he had given a proper warning. This case predates *Bolam* but would still have been extremely unusual at the time as the law has usually found in favour of the medical profession. They generally appear reluctant to challenge medical judgement, perhaps because they feel unable to comprehend medical practice. It may well be relevant that this case involved a physiotherapist. The Courts may have felt that the expertise of the physiotherapist is less esoteric than that of doctors and may therefore have felt less wary of judging it (Montgomery, 1997).

One of the problems with the professional standard is that it can allow pervasive negligence to continue. For example, if all physiotherapists decided to stop performing
vertebral artery testing prior to carrying out a cervical manipulation this would be acceptable according to the professional standard. This standard also creates potential for physiotherapists, or other health care professionals, to close ranks to protect professional colleagues. The main objection, however, is that it detracts from the patient’s right to autonomous choice. The patient has a right to know that there are risks inherent in manipulation of the cervical spine and be allowed to make an informed choice, based on the results of a vertebral artery test, before deciding whether or not to proceed with treatment. Another and more fundamental objection is that physicians do not necessarily know what information is in the best interests of their patients and so cannot decide for them. Veatch (1995) goes so far as to question whether health care professionals can even know what is in the best medical interest of the patient quite apart from issues concerning their general interest. Even though most patients consult a health care professional because they are seeking better health this may not be their only, or even their primary, concern. Each patient will have her own values, goals and interests and her own view of what constitutes health. This is especially relevant in today's pluralistic society where individuals have extremely diverse value systems. A further argument is that even if the health care professional does have appropriate knowledge to make the decision for the patient it does not follow that they ought to do so.

The reasonable, or objective, patient standard states that the information to be disclosed is the information that would be required by a hypothetical reasonable person. Proponents of this standard believe that the obligations to respect autonomy generally outweigh the obligations of beneficence and that this standard more adequately protects the patient’s right of self-determination (Beauchamp & Childress, 1994). This standard was set in the United States by three cases - Canterbury v Spence (464 F2d 772 (DC 1972)), Cobb v Grant (104 Cal Rptr 505 (1972)) and Wilkinson v Vesey ((295 A.2d 676(R.I 1972)). In order for a negligence claim to be successful, not only must there be a duty and a breach of that duty but it must also have resulted in, or caused, actual damage to the patient. In Canterbury v Spence the Court had to decide whether the causation test be subjective or objective. The subjective standard asks whether this patient would have refused the treatment if he or she had all the information whereas
the objective standard asks whether a reasonable, hypothetical patient would have accepted or refused the treatment. The Court was concerned that the subjective view would "place the physician in jeopardy of the patient's hindsight and bitterness" and so chose the objective rule. It defined a material risk as follows: "a risk is material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy".

In Australia the conflict between the two standards - the American centred reasonable patient standard and the British practitioner standard - was squarely faced in the case of Rogers v Whitaker ((1992) 109 ALR 625) in 1992 (Chalmer & Swartz, 1993). In this case a patient was not warned of a risk, estimated at only about 1 in 14,000, but of particular significance to her. The Court heard that Mr. Rogers had acted in accordance with the physician -orientated rule in that several ophthalmic specialists gave undisputed evidence that they would have acted just as he did and would not have warned Ms Whitaker of the chance of sympathetic ophthalmia. However, despite this, in similar words to those used in the Canterbury judgement it was agreed that "a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it". This judgement was a firm rejection of the Bolam principal and acceptance of the reasonable person standard. However, while rejecting Bolam it remains equivocal about the reasonable patient standard, seeming to go along with the subjective view of the patient, whether reasonable or not. It was a judgement that Nisselle (1993a) claimed would "irrevocably alter medical practice in Australia and will resonate both across the Tasman and around the world" (p.331).

The reasonable patient standard has been criticised, largely from within the medical community, as being impossible to satisfy. Practitioners claim that it will greatly increase consultation times resulting in a decrease in level of service (Nisselle, 1993a). Arnold, writing in 1992, after the Rogers v Whitaker decision, still argues that the
information given to patients should vary according to the severity of the disease and the potential for benefit of the intervention. "In general", he says, "if surgery or a diagnostic procedure is considered necessary, by objective standards, for the patient's well being, there may be less need to spell out every possible consequence" (p.335). He suggests that the "neurotic patient with a vague illness" should be given complete information about every possible intervention and consequence whereas, at the other end of his scale, the "patient needing treatment of a potentially fatal disease" would only need warning about the inevitable unpleasantness of surgery. He says that there seems little point in "spelling out every horrendous possibility when the risks posed by the disease itself are so great" (p.336). Others, however, claim that even the reasonable person standard does not go far enough in that the onus is still on the patient to establish, not only that he or she would have refused treatment if fully informed, but also that a reasonable person would also have rejected the proposed treatment. Brazier (1987) holds that "the right to be wrong, to act on individual preferences, to act against one's best interests as perceived by others, is unprotected even by a "reasonable person" test" (p.187).

Brody (1989) suggests that the reasonable patient standard tends to send an undesirable or mixed message to the practitioner. The message that the practitioner hears is that she must explain all the possible risks as well as all the possible benefits and alternatives. Yet this is still not adequate because if she discusses fifty different risks with the patient and the patient suffers the fifty-first, which she forgot to mention, the physician might subsequently be found liable for incomplete disclosure. The result is that in the dialogue between provider and patient risks are over emphasised and information disclosure can become more important than shared decision making. In the physiotherapy setting, where risks are often negligible and where many different modalities are used in treatment Brody's "transparency standard" of informed consent might be more appropriate. Here the physiotherapist would disclose to the patient the basis on which the proposed treatment has been chosen and why other treatment methods have been rejected. The physiotherapist 'thinks aloud' and allows the patient to question the thinking process.
Another standard that has been proposed is the subjective standard. In this model the adequacy of information is judged by the specific needs of a specific patient. It has many problems as a legal standard but is arguably the preferable moral standard (Beauchamp & Childress, 1994). Brazier (1987) not only considers it to be a better moral standard but also holds that it is better in that it provides a more certain framework for doctor patient communication than either the professional practice or the reasonable person standard. This is because doctors do not have to make an assessment of the needs of some hypothetical person but of the actual individual before them. In the physiotherapy setting the physiotherapist should consider the information needs of the specific patient and tailor information accordingly. For example, if the patient has a painful sprained ankle and this is treated with transcutaneous electrical nerve stimulation (TENS) the patient must be warned that the pain has only been masked and the underlying ligament damage is unaffected by the treatment. If the physiotherapist knows that the patient is a professional rugby player the patient must be warned of the specific dangers of returning to training and the risk of further ligament damage occurring if this advice is ignored.

In New Zealand the Accident Rehabilitation and Compensation legislation has meant that there have been very few legal cases. This will be discussed further in relation to the Code of Health and Disability Consumer's Rights.

iv) Comprehension

Patients have the right to receive information in such a way that they are able to understand it. Consumer's comprehension can be threatened by many factors including immaturity, irrationality, fear, anxiety, power imbalance and the illness itself. Some health care professionals have always found it difficult to communicate effectively with their patients and avoid the use of "medical" language. Some have argued that the concepts involved are too difficult for the patient to comprehend and prefer the beneficent and paternalistic approach of the past. This may, however, have more to do with "their own shortcomings as communicators than with their patients' inability to
understand" (Faulder, 1985, p.41). Gillett (1988) also agrees that although this standard of communication can be quite difficult it is the responsibility of the physician to try to do it "as well and as sympathetically as possible" (p.794). While the truth to be told may be brutal, the telling of it should not be. To further aid communication information should be given to patients in an unbiased way and without the appearance of haste. Terms, which can be misinterpreted, such as "likely", "probable" and "moderate" should be avoided.

Informed consent and physiotherapy

All of the legal issues discussed so far relate to the relationship between the doctor and the patient and until recent years the physiotherapist has always assumed that consent to treatment has been obtained by the doctor and covers physiotherapy treatment. As previously mentioned this is no longer sufficient. Most patients referred by the medical profession come with little more than a vague diagnosis and a request that the therapist treat as appropriate. Also increasing numbers of patients are self-referred and so have not been screened by a doctor. While the vast majority of physiotherapists rejoice in this new found freedom it is not so readily realised that this freedom can also bring with it new responsibilities. Although there have been no cases where a physiotherapist has been brought before a court of law on an informed consent-related charge (Purtilo, 1984; Scott, 1991), consent is often seen merely as a legal protection. This is an insufficient understanding. Informed consent has many positive aspects in fostering trust and improving communication between physiotherapist and patient (Purtilo, 1984), improving patient compliance (Sim, 1986a) and allowing the patient to accept responsibility for their own decisions (Coy, 1989). It also allows patients to regain a sense of control of their lives. There is also a belief that the patient who has a clear understanding of how the physiotherapist came to the diagnosis, clearly understands the modes of therapy available, the reason why the physiotherapist has recommended one form of therapy over another and who is actively involved in the decision to proceed will often benefit more from the treatment (Nisselle, 1993b). The physiotherapist would do well to remember that the word "consent" is derived from the Latin "consentire"
which literally means "to feel or think together". This is exactly what the informed consent process should involve. Campbell (1991) states that what the patient seeks is the "provision of the kind of information that will allow a sense of active choice to be restored, in place of the oppressive loss of control which illness brings" (p.36). However, just because positive outcomes result from allowing patients to be involved in the decision making process it would still be important, ethically, even if there were no positive outcomes because it shows appropriate respect for autonomy.

Physiotherapists must now be responsible for informing all patients of the risks and benefits of treatment and for obtaining their informed consent. Sometimes this will involve sharing with the patient the practitioner's own uncertainties, more so with some treatment regimes than others. This sharing of information and especially sharing of uncertainty can result in a dramatic power shift. For example, when confronted with a patient with a painful shoulder there are many different mobilisation techniques that can be used and it is not always obvious from the initial examination which will be most effective. The physiotherapist can choose to share his uncertainty with the patient - "I'm not sure if this particular mobilisation technique will help your pain but I think it seems the most likely one to help you. I'll try it today and then, if it doesn't help I can try a different technique at the next treatment". If the physiotherapist chooses to do this, the patient will come to see that the physiotherapist is not setting himself up as an infallible expert who has all the knowledge and power and a more equitable relationship will result. Patients, in this situation, are more likely to feel that they are active partners in the decision making process. As physiotherapists increasingly come to base their treatments on the results of well conducted research there should be fewer examples of professional indecision.

If patient autonomy is to be respected then consent must be gained even if only one treatment exists because there are always two options open to the patient - treatment or non treatment (Coy, 1989). This is a point perhaps not clearly understood by the British Chartered Society of Physiotherapy who state in their rules that the risks and benefits of a treatment plan should be outlined to the patient so that they can, if appropriate, make an informed choice (CSP rules, 1996, rule 2). Whatever the patient's decision this must be respected, for, as Gorovitz (1982) reminds us "the right to choose
is not limited to the right to choose rightly" (p.12). Autonomy and the right to self determination includes the right to make decisions based on factors other than pure reason. However, once the patient has made an autonomy-enhancing, informed decision not to comply with the treatment that has been outlined, the responsibility for the consequences rest with the patient. This might be difficult for the physiotherapist to accept whose Code (The Code of Ethics of the New Zealand Society of Physiotherapy) emphasises that the physiotherapist must always act in the best interests of the patient. However, there are times when "competent adults should be allowed to make tragic decisions...it is not medicine's responsibility to prevent tragedies by denying freedom, for that would be the greater tragedy" (Engelhardt 1975, in Kliever, 1989, p.46). There was a recent example of this reported in the Otago Daily Times in which a young disabled couple were found dead in their home. It appeared that Mr. Morris had died from an epileptic seizure and his wheelchair bound wife, who had cerebral palsy, was unable to move or call for help. It was thought that she had died of dehydration. The couple had previously been offered an alarm to use in just such a situation but they refused. It was reported that they "took obvious pleasure in their independence".

There has been some discussion in the physiotherapy literature as to whether consent should be written or oral and how consent should be recorded. As a general principle written consent is required when non-routine treatments or procedures are to be carried out and which have risks and complications attached to them. The more extensive, invasive, specific and risky a procedure is the more important it is to establish that consent has been obtained. In these situations a written consent form provides documented evidence (Retsas & Forester, 1995). This not only protects the practitioner in the case of litigation but it also provides the patient with written information. In a recent case referred to the Health and Disability Commissioner there was a dispute between the consumer and the provider about whether or not a neurological examination was carried out. The Commissioner stated in her opinion that "in the absence of any documentation confirming that he took appropriate neurological tests, I have concluded that the provider did not perform a neurological examination" (Report on opinion – case 97HDC4720). The Rules of Conduct of the Chartered Society of Physiotherapy maintain that consent by implication or word of mouth is usually
sufficient because physiotherapy does not, on the whole, include risk-taking procedures. Consequently they state that "it is inappropriate and unnecessary for physiotherapists to use consent forms on a regular basis"(p.10). According to their Rules procedures that may require such a form are movements of force to the cervical spine, vaginal and rectal examinations and exercise tolerance tests from cardiac patients. The reason that these procedures are specifically mentioned is not just because of the risks attached to them but, in some cases, it is also because of their intimate nature. As argued above it is questionable that these are the only occasions when physiotherapy treatments carry the risk of significant harm. Serious harm can result from careless technique, failure to eliminate patients with contraindications to particular forms of treatment, the risk of burns from thermal treatments and in the use of pain masking modalities such as TENS. The physiotherapist should remember, however, that a signed consent is not necessarily a legal safeguard if the process by which it was obtained is defective or if the physiotherapist is negligent. A similar situation exists for patients visiting their General Practitioner. Most of the procedures carried out in the G.P's rooms - recording blood pressure, listening to heart rate, examining ears and throats - are all risk free and tacit consent is assumed. Nevertheless there will be times when explicit consent is necessary.

Manipulation of the cervical spine is one procedure in physiotherapy that has significant and serious risks associated with it. In 1988 the Australian Physiotherapy Association (APA) formalised a protocol for premanipulative testing of the cervical spine. The standards require the physiotherapist to gain informed consent from the patient and the following was suggested as the wording to be used:

I wish to manipulate your joint using a quick movement in the position in which I am holding your neck. You may hear a click and this is normal. Neck manipulation can be dangerous but this is extremely uncommon. I have carried out the recommended precautionary test and in my opinion there is little risk in your case. Are you agreeable for me to go ahead? (APA, p.100)
This, in today's climate, sounds paternalistic and inadequate. However, when Delany (1996) carried out a straw poll in 1995 she found that many physiotherapists failed to comply with even this level of information sharing. Physiotherapists made comments such as "I don't bother (warning them of risks) because the risk is too small", "Sometimes I do, but mostly it interrupts the flow of treatment", "I don't bother telling them because they wouldn't consent" and "Some patients ask you to crack their neck so I don't bother telling them much because they have asked for it" (p.250).

New Zealand physiotherapists also follow the Australian protocol for cervical manipulation and it is clear that in the light of the Rogers v Whitaker case and the New Zealand Code of Health and Disability Services Consumer's Rights the APA protocol is in need of revision and physiotherapists are in need of education as to its relevance and importance. This issue is discussed by Haswell (1996), a New Zealand physiotherapist. She describes an encounter with a patient whom she considered would benefit from cervical manipulation. The patient was given information about the risks of the procedure including a simple description of the anatomy of the cervical spine and the relationship of the spinal cord and blood vessels. The physiotherapist also discussed with the patient the advantages and disadvantages of cervical manipulation as compared with another treatment, cervical mobilisation techniques. The patient was informed that although the premanipulative test had revealed no abnormality there is, according to some physiotherapists, an element of unpredictability about the test itself (Rivett, & Reid, 1998). The physiotherapist also gave the patient her recommendation and then gave the patient time to ask questions and reflect on the information before giving her decision. This process, described by Haswell, reflects the requirements of the Code of Health and Disability Services Consumer's Rights more clearly than does the protocol laid down by the APA and should be adopted by New Zealand physiotherapists. It is also an example of power sharing, as discussed previously, where the physiotherapist shares her uncertainty with the patient.

Another problem for physiotherapy is that it is primarily a handling profession and almost all treatments involve touching, often with the body of the therapist and that of the patient in close proximity and with the patient in an undressed state (see fig.2). This
handling and contact must be carefully explained to the patient to prevent misunderstanding and misinterpretation that could cause offence or could lead to legal action. The New Zealand Physiotherapy Board has dismissed several members in recent years for unprofessional conduct in this area (New Zealand Physiotherapy Board, Newsletter 31 January 1996). Consent needs to be obtained before touching takes place although it seems reasonable that this consent can be assumed by the patient's cooperation with a procedure that has been carefully explained. If, for example, the physiotherapist states that he/she wants to examine the patient's knee and asks the patient to take off their trousers and get onto the examination plinth the patient's consent to this procedure can be implied if they carry out the physiotherapist's directions. Implied consent, however, must be specific to the action. The mere fact that the patient has presented himself in the physiotherapy department cannot be taken as implied consent for any physiotherapy intervention. There are some instances where express oral consent is needed especially when modalities are used which carry a risk of discomfort or hazard, invasive techniques and procedures that may imperil the patient's sense of dignity and propriety. Consent must be obtained by the health care professional who is to carry out the specific treatment and should not be gained by another person - the physiotherapy aide, for example.

Informed consent is a collaborative, truth telling process that requires a high degree of emotional maturity on the part of health care professionals. They must "be willing to answer what is answerable and to admit what is not known; they must throw off the cloak of mystery and superiority that has so long separated health care professionals from patients" (Brazell, 1997, p385). This is imperative for the physiotherapy profession as it looks towards the future. The words of Justice Kirby (1983) are as true for physiotherapy as they are for medicine:

The days of paternalistic medicine are numbered. The days of unquestioning trust of the patient also appear numbered. The days of complete and general consent to anything a doctor cared to do appear numbered. Nowadays doctors, out of respect for themselves and for their patients, (to say nothing for deference
to the law) must increasingly face the obligation of securing informed consent from the patient for the kind of therapeutic treatment proposed (p.74).
Confidentiality is not the same as privacy, although the two often overlap. Privacy is a broad concept and restricts initial access to people and information whereas confidentiality governs the use that the information is put to once it has been collected. Issues concerning physical privacy are dealt with in the Code of Health and Disability Consumer’s Rights (Right 1 (2)). The Privacy Commissioner has pointed out that presumptions that information privacy and information confidentiality are the same have led to misconceptions about the Health Information Privacy Code. He states that "it is important to make the distinction between confidentiality and health information. Privacy of health information does not equate to confidentiality - the terms are not interchangeable" (Slane, 1995a, p. 102). Privacy is a key aspect of human dignity. Having a private life is central to the development of individuality and self-knowledge. Privacy is a valued right in a democratic society and we value it, according to Inness (1992), because we "value respecting others as persons in the emotional sense, persons with the capacity for love, care and liking. Privacy embodies this respect by protecting the autonomy of the individual" (p. 139). Beauchamp and Childress (1994) note that actual privacy is distinct from one’s sense of privacy. If a person’s privacy is invaded it will not affect their sense of privacy if they have no knowledge of it and it is also possible for a person to believe that their privacy has been invaded when it has not. The patient who believes that the physiotherapist has discussed their case with another patient will feel that their privacy has been lost, even if this is not true. They will feel that they have lost the power to control the flow of information about themselves, even if they have not.

There are three principal arguments as to why it is important to keep confidences (Beauchamp & Childress, 1994). One is a consequentialist argument that if patients are sure that the health care professional will respect their confidences then they will be more likely to disclose information. This in turn will lead to a better outcome in terms of better health and welfare and so greater general happiness. The second argument is from duty and states that respecting confidentiality is important in that it demonstrates appropriate respect for an individual’s autonomy, quite apart from any consideration of the consequences. As Brody (1992) says, the health care professional who "details his patients' intimate secrets as cocktail party chit-chat acts in a morally outrageous
fashion, independently of whether any harm comes to the patients themselves as a result of his disclosures" (p. 124). Thirdly there is an argument based on fidelity. There is an understanding, implicit or explicit, that the health care professional will respect patients' confidences and to violate this understanding would disrupt the special nature of the professional relationship.

One might ask why people regard confidentiality as such an important principle. It is probably because it is the possession of different degrees of information that characterises and delineates our personal relationships. The closer someone is to us the more personal information about ourselves we are likely to share. This means that we can regulate the nature of our relationships with others by maintaining control over the flow of information. The health care professional has a unique place in that most patients would not count their physician or physiotherapist as one of their intimate circle of friends but, nevertheless, he or she is privy to personal, intimate and perhaps potentially embarrassing, information. If health care professionals disclose information to a third party that the patient wanted kept confidential they are not only betraying the special nature of the relationship between the professional and the patient but they are also robbing the patient of the power to control their relationships with others.

Seigler, writing in the New England Journal of Medicine in 1982, described confidentiality as "worn out, and useless; it is a decrepit concept" (p.1518). What's more, he believed that all efforts to preserve it were doomed to failure. He made this comment when, after a patient asked him to guarantee that his hospital records were being kept confidential, he counted the number of health care professionals who had a legitimate reason to see the patient's notes. He was horrified to discover that it was in the order of a hundred people. Seigler reported this to the patient who, obviously distressed, retorted, "I always believed that medical confidentiality was part of a doctor's code of ethics. Perhaps you could tell me just what you people mean by 'confidentiality'!" (p.1519). Health care professionals should make it clear to patients just how widely case notes are read and also to remember this themselves when adding comments to them. Medical notes should be a record of objective findings and not a vehicle for personal comments about the patient. Information should only be recorded if
it is both true and relevant and any questionable information (for example information that the health care professional believes to be true but has been unable to verify, or information that the health care professional believes to be true but the patient disputes) that is recorded should be marked as such. The Health Information Privacy Code gives patients the right to access information held about them and to request that it be altered if it is untrue (Rules 6 & 7).

Exceptions to the rule of confidentiality

According to Gillon (1985b) and Beauchamp and Childress (1994) confidentiality is a prima facie duty and so there are occasions when it can be breached. Sometimes it is permissible to breach it and sometimes there is an actual obligation to breach it. However, it can only be broken if it can be shown that there are significant and legitimate reasons for doing so and the onus of proof is on those who wish to breach it. There are some commonly recognised exceptions to keeping confidentiality. Common exceptions include situations where there is a legal obligation to disclose, when other health care professionals have a need to know in order to facilitate patient care and when the professional believes that the public interest, or the interest of another person, overrides the duty of confidentiality. This latter situation is the most common conflict to occur with respect to confidentiality.

Confidentiality and the law

Three elements are required by law to establish a breach in confidentiality:

1) The information divulged must have the necessary quality of confidence about it.

2) The information must have been acquired or imparted in circumstances importing an obligation of confidence.
3) There must have been an unauthorised use of the information resulting in harm.


The law, at various times, requires disclosure of medical information. For example some infectious or communicable diseases are notifiable. In these cases the health professional is not liable for a breach of confidence. Sometimes patients themselves give permission for information to be passed on. However, Allmark (1994) remarks that confidentiality is not important because of the law but rather the law recognises that confidentiality is important. Coleridge, J. who said "a legal common law duty is nothing else than the enforcing by law of that which is a moral obligation without legal enforcement" also upheld this (In *R v Instan* [1983] 1 QB 450 at 453).

On rare occasions the patient may be thought to pose a serious risk to a third party and the health professional may consider disclosure to that third party. Such a situation was considered in *Tarasoff v Regents of the University of California* (551 P2d 334 (1976)). In this case a patient told the psychotherapist who was treating him that he intended to kill Tatiana Tarasoff. The patient subsequently did kill Tatiana and her parents sued the therapist alleging a negligent failure to warn their daughter of the threat. While the court recognised the importance of confidentiality in doctor-patient communications the majority verdict was that, at times, other things are more important. Tobriner, J. said that confidentiality "must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins". The *Tarasoff* case has led to the idea that there is a common law duty to disclose information in order to prevent harm. However there is no obligation to disclose. In a court case in New Zealand, *Duncan v Medical Disciplinary Committee* ([1986] 1 NZLR 513), a similar situation was considered. A public bus driver underwent coronary by-pass surgery and was, subsequently, certified as fit to drive by the surgeon. However, his General Practitioner asked for his licence to be withdrawn. The driver complained that his General Practitioner told the police, members of the general public and
eventually the media, details of his confidential medical history in an attempt to prevent him driving the bus and, in the opinion of the doctor, endangering passengers. The High Court found that the doctor's disclosure had been inappropriate and found him guilty of professional misconduct (at 518). Nevertheless the Jeffries, J. supported the idea that there are occasions when disclosure is necessary. He said:

There may be occasions, they are fortunately rare, when a doctor receives information involving a patient that another's life is immediately endangered and urgent action is required. The doctor must then exercise his professional judgement based upon the circumstances, and if he fairly and reasonably believes such a danger exists then he must act unhesitatingly to prevent injury or loss of life even if there is a breach of confidentiality. If his actions later are to be scrutinised as to their correctness, he can be confident any official inquiry will be by people sympathetic about the predicament he faced. However, that qualification cannot be advanced as to attenuate, or undermine, the immeasurably valuable concept of medical confidence. (At 521)

Although the most defensible reason for beaching confidentiality is to prevent harm to another individual it is not as straightforward as it might appear. It is very difficult to predict the good consequences of breaching the confidentiality and the benefits of doing so are hypothetical in that patients may change their mind about the threat they have made, or the threat may be otherwise averted. However the bad consequences of a breach are more predictable. The relationship between the health care professional and the patient will be damaged and patients in general may become less willing to divulge information resulting in poorer medical outcomes. Tucker (1998) suggests that if a health care professional is accused of having made the wrong choice in a given situation the only answer they can offer is that they acted “in an honest belief that was formed through the application of professional skill to the situation at hand” (p.380).

Confidentiality is not mentioned in the Code of Health and Disability Consumer's Rights. Right 1(2) says that the consumer has the right to have his or her privacy
respected but this refers to personal physical privacy and not information privacy. This is because issues of privacy concerned with health information and confidentiality are covered in the Privacy Act and the Health Information Privacy Code. The Privacy Act and the Health Information Privacy Code are focused on individual autonomy and the empowerment of the individual to exercise some degree of control over what personal information is held about him or herself and what it can be used for (Slane, 1995b).

**Health Information Privacy Code 1994**

The Privacy Commissioner can, in accordance with the Information Privacy Principles set out in the Privacy Act, issue codes of practice modifying the principles in the Act to take into account the special characteristics of specific industries, agencies or types of information. Consequently, the Health Information Privacy Code came into force in July 1994. It was amended in July 1995. The amendment was needed to take into account the definitions of health professional that were used in the Code of Health and Disability Consumer's Rights. The Privacy Commissioner, Bruce Slane, explained that a special Code was needed for the health sector to take account its special characteristics, in particular:

- **Confidentiality of collection** - most health information is collected in a situation of confidence and trust, often in the context of a therapeutic relationship;

- **Sensitivity of information** - much health information is highly sensitive and may include information about an individual's body, lifestyle, behaviour and practices which are particularly intimate or which may, if improperly disclosed, be misused;

- **Ongoing use** - health information may be required long after it has ceased to be needed for the original episode of care or treatment. (Introduction to the Health Information Privacy Code p.2)
Health information, collected by health care professionals and kept in medical records, can include sensitive personal information such as details of family history, results of genetic testing, details of sexual orientation and practices and any history of drug use. Records may also contain subjective remarks about a patient’s character, mental state and coping ability. This information is needed to provide comprehensive, good quality care. However, it can also be used to make important, non medical decisions, such as a person’s ability to enter a particular course of training, secure employment or obtain insurance. Inaccuracies in information, or the improper disclosure of information, can therefore threaten an individual’s personal and financial well being as well as his or her health care.

The Health Information Privacy Code is intended to help health care professionals to comply with the Privacy Act in that it:

- Uses language that has been tailored to the health sector.
- Includes some limited and specific exceptions, tailored to the health sector, where difficulties in complying with the principles are anticipated.
- Has a (non-binding) commentary with illustrations specific to the health sector.
- Makes reference to “representatives” of people unable to act for themselves.
- Has been simplified by the removal of some principles that have no relevance to the health sector.

The Health Information Privacy Code has twelve rules. Rules 1, 2, 3 and 4 relate to the collection of information. The first rule states that all information collected must be collected for a lawful purpose and must be relevant to the purpose for which it is being collected. For example it would be inappropriate for the physiotherapist to ask a patient for details about their living arrangements when treating them as an outpatient for a stiff neck but highly appropriate to ask the same question when assessing mobility prior to discharge following surgery for a hip replacement. The commentary in the Code (p 8-9) also states that while information is predominantly collected to assist in care and
treatment it can also be collected for other purposes such as for teaching and training and for the administration of aspects of care.

As far as possible information must be obtained directly from the individual concerned (Rules 2, 3 & 4), except in certain specified situations. Although health care professionals cannot solicit information from others, any other person can give information to the health care professional and this information can be recorded. Patients must understand why information is being collected and with whom the health care professional intends sharing it. Patients should be told if interviews are being video taped or recorded or if information gained is going to be used for teaching purposes. Explicit consent will be required in these instances. The Commissioner states (Health Information Privacy Code 1994, p.10 & 13) that this requirement emphasises and recognises the need for informed consent. Rule 5 deals with requirements to keep information secure. Physiotherapists must decide therefore, how long patient records will be kept, where they will be stored to ensure their safety and when and how they will be disposed of.

Rules 6, 7 and 8 detail a person's right to access information held about them and to ask for it to be corrected if necessary. If a request for correction is refused, perhaps because the agency holding the information is satisfied that it is correct or that it fairly represents the opinion held at the time, the individual can request that a statement that correction was sought but not made, be attached to the information. Practitioners should also be aware that if a patient requests information that the provider no longer has, perhaps because the patient has been referred to another provider and the notes have been sent on, the request must be passed on to the new provider. Having a right of access to personal health information is an integral part of informed consent. For individuals to be able to make appropriate decisions about treatment choices they need to understand the nature of their illness. Entitlement to personal information is subject to a limited number of reasons to refuse access (Privacy Act Ss 27-29) but patients do not have to divulge their reasons for wanting to see their personal health information.
For the purposes of the present discussion on confidentiality the important rules are rules 9, 10 & 11 which set the limit on disclosure of health information. Rule 9 states that information collected about an individual must not be retained for longer than is necessary. In common with most Codes of Professional Practice, and like the NZSP Code, the Health Information Privacy Code allows disclosure of information with the individual’s consent, and without their consent, if the individual cannot be identified. Information can also be disclosed if the disclosure is directly related to one of the purposes in connection with which the information was obtained (rule 10). So it is quite permissible for the physiotherapist to give information about a patient’s condition and progress to the referring doctor or to another health professional involved in the patient’s care. Another statutory provision, which is concerned with the transfer of information between health care professionals, is s22 (f) of the Health Act. This provides that a person who is to provide health services to an individual can request information from another agency that holds information about the individual concerned. There are certain, limited, grounds for withholding the information but otherwise it must be communicated. This is also in accord with the Code of Health and Disability Services Consumer’s Rights which says that consumers have the right to cooperation between providers to ensure quality and continuity of services (Right 4(5)).

Rule 11(2)(d) also states that disclosure is permissible if it is necessary to prevent or lessen a serious and imminent threat to public health or safety or to the life or health of individuals themselves or to another person. In the explanations that accompany this clause the Commissioner makes clear the importance of the words "serious" and "imminent" although it can be claimed that what these words actually mean may only be able to be assessed in retrospect (p.32). Disclosure should only be to the extent necessary to meet the particular purpose. When considering breaching confidentiality the health care professional should be sure that the harm to be avoided is serious and that there is no other practical way to avoid the harm other than by breaching confidentiality. In cases such as these the health care professional should also give the patient the opportunity to voluntarily disclose the facts before intervening. If the

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1 It should be noted that while the commentary to the Code is provided to assist understanding it is not part of the Code and is not legally binding. In all cases reference should always be made to the actual wording of the Code itself.
decision is made to disclose confidential information then the health care professional must ensure that the disclosure is made to an appropriate person or agency. In the *Duncan* case the doctor was censured by Jeffries, J. because he made his disclosure to lay members of the public who were in no position to prevent the potential harm (At 521). Generally public safety can be best served if confidentiality is maintained in the usual case and by releasing information in the exceptional case.

In their assessment of the Health Information Privacy Code the Medical Council of New Zealand suggest that disclosure can be made if the health care professional believes, and can justify his or her belief, that:

- there is a serious threat to public safety or to the safety of the patient or another individual
- the threat is imminent
- disclosure will prevent or decrease the risk
- the patient must be identified in order to decrease the risk
- the person to whom the information is revealed is in a position to avert the danger.

(Confidentiality and the Public Safety. A statement by the Medical Council of New Zealand. 1998, p.3)

Whatever the law says, or does not say, about confidentiality some health care professionals will still hold that there are sometimes ethical duties which are more important than legal ones. Beauchamp and Childress (1994) make the point that difficult moral dilemmas cannot be resolved merely because there is a law that requires disclosure. As stated in the commentary to the Health Information Privacy Code, the agency is not *obliged* to disclose information in Rule 11 and just because an exception to the rule clearly applies the agency may still decide not to disclose.
Confidentiality and physiotherapy

As previously stated the issue of confidentiality has been mentioned in the literature as of concern to physiotherapists. Participants in interviews have also mentioned it. (Barnitt, 1994). One interviewee said "The staff gossiped about the patients and often their information was totally wrong by the time it had done the round" (Barnitt, 1993, p.211). Care should be taken when discussing individual patients in the lift, cafeteria and changing rooms. As more and more people have direct access to a patient's records the potential for this kind of breach of confidentiality increases dramatically. Office personnel and other team members can access patient information; clients may consult many different health care professionals who must, in turn, consult with each other; information may also be needed by employers, law enforcement agencies, the ACC and third party payers. In order to demonstrate that they take the matter of respecting patients' confidentiality seriously physiotherapists should ensure that, if they read the patient's case notes, they have a clear reason for needing to do so. Gillon (1985b) says that even when health care professionals do have a need to read patient's notes it would be a relatively straightforward thing to ask the patient's permission first. "Good morning Mrs. Jones, I've been asked to give you physiotherapy, do you mind if I consult your notes to see what would be best for you?" (p.1636).

Physiotherapists, like all other health professionals, need to address these issues in their own practice. Care must be taken with the public display of appointment books, conversations that can be overheard and information given over the telephone to third party payers, employers or relatives. Consider the following case:

Case 3:

A fourteen-year-old boy has been attending for physiotherapy in a private practice for the past three weeks. One morning the physiotherapist receives a telephone call from the boy's school to ask whether the boy had attended for physiotherapy on certain specific dates as the school are concerned that he is using physiotherapy appointments as an excuse to miss extra classes.
Can the physiotherapist give out this information about the patient, or would it constitute a breach in confidentiality? Many physiotherapists would probably claim that it was a breach in confidentiality, but this can be disputed. From the definitions discussed earlier, in order to qualify as confidential, information has to have been imparted in confidence with the expectation that it will not be divulged. The information about attendance does not seem to have these aspects to it in that the boy had clearly told the school authorities that he was attending for treatment. There are many situations in health care where information is not formally "entrusted" to the health care provider. Frequently what the health care provider has in these situations, rather than a duty of confidentiality, is a professional obligation to be discreet - to have respect for the individual patient and for their privacy. Information should be treated with discretion, even if it is not strictly confidential. The advice of the Privacy Commissioner is to put oneself in the position of the individual and "ask what you would want done in their particular situation" (Slane, 1995a, p.102). In the above case if the boy has indeed been attending for physiotherapy on the days in question it would seem reasonable to assume that he would want this fact confirmed so that he does not get into trouble at school. In the words of Bok (1983), "at times, the insistence on secrecy can become obsessive, so that confidentiality may come to surround the most trivial matters, even when less secrecy could be useful, not only to oneself, but to others" (p.28).

Nevertheless, the physiotherapist should still attempt to ask the boy for his permission to disclose the information about his attendance before discussing it with the school. If this is not practical the physiotherapist may still be able to justify giving the information if she can show that it is not practical, in accordance with Rule 11(2), and that it has not been expressly forbidden by the patient (Rule 11(2)(b)). If the patient has never attended for physiotherapy treatment there is no reason why the physiotherapist cannot give this information as she has no relationship with the patient and therefore no duty of confidentiality.

In the physiotherapy setting it is easy to think of situations involving issues of confidentiality which might occur on a regular basis and which the physiotherapist can
plan for in advance. For example, it would be good practice to ask all school age children who attend alone for treatment what information they are happy for the physiotherapist to give to their school or to their parents. Many physiotherapists are also involved in providing physiotherapy services to sports teams. They may be asked for information about a player's progress or ability to return to competition by the team's coach or manager. The physiotherapist and the player can agree in advance the extent and nature of information that can be shared with the coach. If the team management is paying the physiotherapist's bill then dual responsibilities come into tension and advance agreement about the sharing of information could prevent difficult situations from arising.

The NZSP Code simply states that "Patients have the right to confidentiality of all information provided and that it shall only be divulged with their permission except when the law otherwise requires" (3.9). This suggests that there need be no disclosure in situations where the law permits rather than requires disclosure. The CSP Code in Rule Three also makes a simple statement that "Chartered physiotherapists shall ensure the confidentiality and security of information acquired in a professional capacity" (p.15). Several pages of explanations and elaboration accompany the statement (pp 15-18). Physiotherapists are told that this duty extends to the fact that the patient is, or is not, attending for treatment. This means that no information can be given to any third party about the patient's attendance for treatment. As discussed in case 3 there would seem to be occasions when one would be justified in disregarding this advice. The text also goes on to say that information can be divulged by the physiotherapist if they are required to do so "by a competent legal authority such as a judge, or where it is necessary to protect the welfare of the patient or to prevent harm, or it is (rarely) justified in the public interest" (p.15).

In order to comply with the Health Information Privacy Code physiotherapists need to consider the information which they routinely collect about patients. The Privacy Commissioner has stated that if health care professionals get the collection of information right by paying more attention to rule 3 of the Code then they are less likely to have a problem with rules 10 and 11. "If you have your purposes clear and
state them openly rules 10 and 11 hold no terrors for you" (Slane, 1995b, p.112).

Patients must be made aware of the reasons why particular information is collected and to what use it will be put. For example some information is collected by physiotherapists because they are required to give it to the ACC in order to receive payment. In this instance the patient should be made aware that, if they wish to receive treatment under this scheme, then certain information will be required and will be passed on to the ACC. The physiotherapist may ask the patient about her job and leisure activities in order to understand how an injury has occurred and to give advice about prevention. Most patients are happy to give these details, especially if they understand why they are being asked. Even if confidentiality cannot be absolute it should be predictable. The patient will not be betrayed by a breach in confidence if he or she knows in advance that a legitimate law requires a breach. As Kottow (1994) states: "If a sound law requires declaration of information, this should be amply known so that all patients are aware that certain matters cannot legitimately remain confidential" (p.477).

Physiotherapists must exercise special care when treating people with a disability. Special care is needed to ensure that their autonomy, which may already be fragile, is not further eroded. In the commentary to Rule 2 of the Health Information Privacy Code the health care professional is reminded that there are concerns about the way in which some agencies deal with some people with disabilities. Personal information about an individual may be obtained from a third party and this, combined with disclosure without the authority of the individual concerned, can undermine privacy and personal autonomy. In "Private Lives" Montague (1993) states that just about anything can be considered as "relevant" information when the person has a disability. Also, once information has been collected it can seem to take on a life of its own without ever being checked for relevance or accuracy. "This information can, in fact, then be quite prejudicial to the person with a disability and can be extremely difficult to have altered or deleted" (p.31). Although Montague was writing about the disabled her statements could be as true for others in the community who have no recognised disability. Patients with any "significant" diagnosis, be it psychiatric or physical, can find that all their problems are attributed to this cause. For example, patients with a
psychiatric history may have their headaches put down to their psychiatric history whereas they may well be caused by pathology in the cervical spine.

One circumstance which may confront the physiotherapist in which the issue of confidentiality might arise is in the case of the patient who is known to have AIDS or be HIV positive. Physiotherapists often come into contact with people with AIDS in the later stages of the disease when they need respiratory treatment. Despite it being clearly established that physiotherapists have a role to play in such cases, the ethical implications do not seem to have been identified in the physiotherapy literature. Many general articles on HIV and AIDS have been published (for example, Lang, 1993; McClure, 1993; Smith, 1993) but only two, (Sim, 1997 and Sim and Purtilo, 1991) have addressed the ethical issues involved.

When confronted by a patient with AIDS the physiotherapist must ask whether or not confidentiality should be breached and other people told of the patient's diagnosis. Sim (1997) gives persuasive arguments that there is no need for confidentiality to be broken. Neither, he claims, is it necessary for physiotherapists to reveal their HIV status to their patients. The reasons he gives are as follows: a) Treatment is not usually invasive; b) HIV or AIDS do not constitute a contraindication to other forms of physiotherapy treatment. While conceding that some physiotherapy treatments are invasive and carry a risk - acupuncture, burns care, wound debridement, internal examinations in gynaecological practices - he states that the use of universal precautions will minimise the risk. "If physiotherapists employ universal precautions in their dealings with all patients, this will not only help to maintain confidentiality, but will also offer the best available protection against HIV transmission" (p. 94).

Another author, while largely agreeing with Sim, disputes his claim that HIV and AIDS have no clinical sequelae that may be relevant to other physiotherapy treatments. She gives as examples drug induced neuropathy, malabsorption leading to patients being malnourished and the effect of immunosuppression on energy levels and consequent tolerance of exercise regimes. However she does not think that this detracts from the conclusion that Sim draws in the "need to know" debate (Lang, 1997).
Additional aspects of confidentiality are the inadvertent, but nevertheless avoidable, breaches in confidentiality that occur through "gossip". Seigler (1982) maintains that these types of breaches of confidentiality are probably of greater concern to the patient than breaches which occur as a result of unauthorised personnel having access to medical notes. The following situation, described by a physiotherapist, interviewed by Barnitt (1998), is a good example of this. She said:

The staff gossiped about the patients to each other, other patients and their relatives, and to any visitors within earshot. I minded more because the information they gossiped about often led to patients being labelled as difficult. (p.195).

Sometimes professionals make the claim that certain information is confidential to protect themselves rather than their patients. In this way confidentiality is used as a shield to keep secret one's own poor treatment, mistakes, negligence or over charging or even one's colleagues' incompetence. Confidentiality can then lead to further error, injury, abuse and even further pathology. Although the premises supporting confidentiality are strong they cannot support practices of secrecy, whether by individuals, institutions or professions, that undermine the very respect for persons that confidentiality is meant to protect (Bok, 1983).
Chapter 2:3: Truth telling

Truth telling and confidentiality are related issues in that they both have to do with the way in which health care providers deal with information about patients. In the case of confidentiality the knowledge has usually come to the professional from the patient but when truth telling is an issue the information that the professional possesses is usually about the patient and the patient is, as yet, unaware of it. While it can be argued that we can never know the whole truth this will not be considered here. What is at issue is what we mean by being truthful. "Truthfulness", says Sim (1986b), "consists in conveying intelligibly that which the speaker believes, perhaps mistakenly, to be an objective representation of the facts" (p.121).

Interestingly, the two matters of truth telling and confidentiality juxtapose one of the oldest pronouncements of medicine with one of its newest (Brody 1992). While the duty of confidentiality goes back to Hippocrates, the duty to disclose everything, including even bad news, to the patient is a recent phenomenon. In the past it would have been considered an abuse of power to disclose distressing information. For example, in 1883 Holmes wrote, "Your patient has no more right to all the truth you know than he has to all the medicine in your saddle-bags... He should get just so much as is good for him" (In Brody, 1992, p.121).

Often the debate over truth telling revolves around the differing views of the impact of the truth on the patient. On one side the health care professional may justify withholding the truth on the grounds that the patient will find the truth distressing - the truth may cause the patient harm and the health care professional has a desire to act in a beneficent manner. On the other side are those who argue that patients, as rational human beings, have a right to the truth however distressing it may be, because lying or withholding the truth, causes a greater harm. Truth telling can also, like confidentiality, be defended on grounds of showing appropriate respect for patient autonomy and it can
also be based on the fidelity expected in the patient/professional relationship. Doctors' perceptions have changed over the past thirty years regarding these two positions. In a well-publicised study by Oken in 1961 it was found that 90% of doctors were unwilling to tell patients of a diagnosis of cancer. However, by 1979, an almost identical study by Novack showed that more than 90% would tell patients of a cancer diagnosis (In Barnitt, 1994). On the face of it this seems a triumph for the principle of autonomy over paternalism but Beauchamp and Childress (1994) suggest that other factors were involved such as the availability of greater treatment options, improved survival rates for some types of cancer, fear of litigation, changes in society's attitudes to cancer and increased awareness of patient rights. There has also been increasing recognition, by all members of the health care team that improved communication usually results in better patient understanding and also better compliance. Brody (1992) adds that by disclosing information health care professionals empower patients:

They empower patients by creating an atmosphere that encourages participation and dialogue; by following carefully the cues provided by the patient as the dialogue unfolds; and ultimately by aiding the patient in placing the new information in the context of the patient's life experience and life story in the most meaningful, encouraging and health promoting way. (p.136)

Cynically, it could be argued that the change simply represents a change in the application of the paternalistic “doctor knows best” approach. Health care professionals may now be disclosing information because it has been shown that it results in better outcomes rather than in order to enhance patient autonomy. However, if knowledge is power, then to be kept in a state of ignorance is to be kept in a state of impotence and dependence. It is to be treated as a child and to be controlled.
Truth telling and physiotherapy

There have been very few articles in the physiotherapy literature regarding truth telling despite the issue being mentioned as one which causes concern in the surveys by Barnitt (1994), Guccione (1980), and Triezenberg (1996).

There has been some discussion regarding whose prerogative it is to tell the patient facts about their diagnosis and prognosis. Is it solely the doctor's or are there occasions when the physiotherapist should tell the patient? Although the Code of Health and Disability Services Consumer’s Rights (in Right 6) clearly establishes the patient’s right to be fully informed it does not discuss who should, or should not, give the patient information about test results, diagnosis or prognosis. There are certainly many occasions when physiotherapists are asked, by patients, to give them information about their diagnosis. There are several reasons why patients may ask the physiotherapist rather than the doctor - the nature of physiotherapy treatment is such that physiotherapists often spend long periods of time with the patient and the touching involved in most treatment may encourage trust and intimacy. The Chartered Society in Great Britain sees the issue as a straightforward one and states clearly that members of the Society must not give information to patients about their diagnosis as this "should only be given by the doctor with overall responsibility for the patient". In this situation the physiotherapist is advised to contact the referring doctor, explain that the patient is requesting this information and also advise the doctor that the physiotherapist has been put in a difficult position (CSP rules p.17). The Code reinforces this in stating that the patient has the right to such cooperation between providers in order to ensure quality and continuity of services (4(5)).

While this advice sounds simple it is less than simple in practice. Most of the surveys suggest that physiotherapists want to be truthful and 'fobbing the patient off' is difficult in practice and may damage the physiotherapist/patient relationship. When truth telling is not practised it leads to "anger, frustration and distress for both therapists and their patients" (Barnitt, 1994, p.339). In Barnitt's survey in 1994 she found that the dilemma over truth telling arose because either the doctor or the patient's family had decided that
the patient should not be told the truth. Physiotherapists then found themselves involved in a deception. Part of the problem is that a wrong has already occurred in that confidentiality has already been breached. The family has been given information which was rightfully the patient's, and then the continued withholding of the truth compounds the wrong. One physiotherapist gave the following example of the dilemma that she found herself in:

An elderly patient with cancer of the lung was referred for therapy. He was to receive therapy twice a day. Both the doctor and relatives (son and daughter) said that he was not to be told his diagnosis or prognosis. The patient constantly asked the therapist if he was going to die and said that he knew that information was being withheld. The therapist met with both the doctor and the relatives to discuss this and asked that the patient should be told. This was refused. The therapist eventually found herself telling lies to the patient because the symptoms of lung cancer became obvious to the patient. The patient died without having been 'told' (p.336).

Sim (1986b) discusses this issue and begins by reminding physiotherapists that they should only reveal that which lies within their field of competence. For example, they should not be discussing surgical procedures and risks, drug interactions or the side effects of radiotherapy with patients. They should confine themselves to their area of expertise - the prospects of restoration of physical function, mobility and independence and the expected outcomes and associated risks of physiotherapy treatment. However, he argues that there are some facts about a patient that might be regarded as “general knowledge” within the health care team and this may include facts about diagnosis, prognosis and the results of tests. If these are established facts, although it may be more appropriate for these to be communicated by the doctor, there may be circumstances when it is entirely appropriate for the physiotherapist to pass such information to the patient. He sees truth telling as a matter of ethics and does not think that the doctor's authority extends to matters of ethics. Judge Cartwright also seems to have been in

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2 See also Code of Health and Disability Services Consumer's Rights, 4(1) and 4(4)
sympathy with this view in her report on the Cervical Cancer Inquiry. The report called for involvement of other staff in decision making - "now the patient must be involved in decisions concerning her management and colleagues must intervene if there is a risk to the patient for any reason. The doctor is no longer wholly autonomous" (Report, p.129).

While the issue of telling patients their diagnosis is the area of truth telling most easily identified, as causing dilemmas for physiotherapists it is not the only area where this issue arises. Physiotherapists can also find themselves involved in telling lies to patients for what they might describe as "good" reasons. This is sometimes seen as lying 'on behalf of' the patient in order, for example, to obtain a piece of equipment that the physiotherapist judges that the patient needs but a third party payer will not fund. Another example, which the physiotherapist might encounter, concerns the discharge from the ward of an elderly patient following a fractured neck of femur. The physiotherapist might be asked to assess the patient's stability and mobility and make recommendations on the assistance that the patient is going to need if she is to manage at home. The ACC will provide a home help in this situation but the number of hours of assistance that are provided will depend on the number of 'points' that the patient scores. The physiotherapist, knowing this, may be tempted to increase the patient's score so as to increase the assistance that the patient receives. She may justify this because she believes that this increased level of help is in the best interest of the patient. In another similar situation the ACC will not fund housing modifications for people who have a life expectancy of less than six months. In this case the health care professional may feel justified in changing the prognosis, in order for the modifications to be carried out, and justify this by claiming, honestly enough, that predicting life expectancy is not an exact science.

Another context in which a physiotherapist may be willing to lie about a patient's progress is in order to secure funding for continued treatment. For example, some third party payers will only continue to pay for physiotherapy treatment while the patient continues to make progress. However, familiar with the "plateau" effect which

1 See also Code of Health and Disability Services Consumer's Rights, 4(1) and 4(4)
frequently occurs, particularly following head injury or stroke and in other neurological conditions, the physiotherapist may be tempted to lie about the patient's progress in order that the treatment can continue. They may justify this by the fact that if treatment does stop during the "plateau" period the patient is likely to deteriorate and consequently need further treatment to make up the lost ground. However, while physiotherapists continue to act like this it is unlikely that changes in funding will occur. It would be better for them to be more vocal in highlighting the inequities and problems that they perceive with the system in order to bring about a change in the rules. Two further points can be made here. First physiotherapists must be sure that their motives are directed towards benefiting the patient and that it is not just a case of well-disguised financial self-interest. Secondly, it could be that the limited resources available are being allocated as fairly as possible. Trying to get a better deal for an individual patient will then result in a worse deal for another patient who might meet the allocation criteria.

Bamitt (1993) also gives examples of health care professionals lying for what she calls "bad" reasons. These included lying to cover up for the incompetence and mistakes of colleagues and to prevent unpleasantness in the team. These, however, are not really examples of ethical dilemmas, as, in a dilemma, one is faced with two or more alternative choices, none of which seems a satisfactory, or preferable, solution to the problem. In the above cases there is a "best" course of action, even if this is difficult or uncomfortable. In the case of incompetent colleagues physiotherapists in Great Britain find themselves being given conflicting advice by their Code of Practice. On the one hand, in rule 4, they are told that they should avoid any criticism of colleagues "either verbally or in writing, to the patient or to any other member of the health care team or to others" (CSP Rules, p.22). In rule 5 they are told that they have a duty to report incompetent practice. The advice given to physiotherapists is that they should "ensure that they maintain their own competency, assist colleagues to maintain their own standards and levels of practice and to report incompetent practice to the appropriate authority in the best interests of patient care" (CSP Rules, p.23). The NZSP Code of ethics is less ambiguous and states that physiotherapists have a responsibility to ensure
that behaviour which may be considered unethical is brought to the attention of the New Zealand Society of Physiotherapy (Rule 4.1).

Whilst telling the truth to patients has become accepted medical practice there are those who question whether truth telling should be the ‘gold standard’ measure in our interactions with patients. Higgs (1994), for example, suggests that there are times when, rather than wanting the truth, patients “cry out for the comfort and kindness of deception” (p.501). There are times, particularly in rehabilitation medicine, when physiotherapists might withhold the truth from a patient in order to protect them from a harsh reality that they are not yet ready to face. In many day to day encounters with patients there may be situations which seem to require the truth to be “bent, folded, redirected or simply screwed up and binned” (Higgs, p.501). While this may be inevitable, the danger for health care professionals is that they may accept this as simply part of their job and fail to recognise the deception for what it is.
Chapter 3: The Health and Disability Commissioner Act: The Background

Medical ethics has a long history going back to Hippocrates who thought about the proper way to practice medicine. The Hippocratic Oath although essentially sexist, paternalistic, secretive and elitist continued to guide the practice of medicine for many centuries. Despite the Oath being updated and revised many times in the 1950's and beyond with the Codes of Geneva, Helsinki and Venice, medical ethics remained largely "in house" (Campbell, Charlesworth, Gillett & Jones, 1997)

The long quiescent period in which the Hippocratic tradition was taken as a given flourished probably because of the homogenous nature of Western society (Pellegrino 1993). However, changing social perspectives in the 1950's, 1960's and 1970's began to impact on health policies and practices. The consumer movement challenged traditional medical paternalism, the feminist movement challenged traditional stereotypes of women, students in America protested against the Vietnam War, there was a heightened sense of ethnicity and various rights movements campaigned for the rights of prisoners and other marginalised groups. At the same time technological advances in the form of sophisticated but expensive diagnostic and treatment equipment meant that the scope of medicine had broadened considerably. It had also become more specialised and fragmented, more hospital-based and consequently less personalised. Science and technology had begun to complicate medical decision-making. There were several events that can be pinpointed as bringing medical ethics into the public arena (Jonsen, 1993; Pellegrino, 1993; Tong, 1997).

1. The Nuremberg trials: The Nuremberg trials brought the whole issue of consent before the public in a stark and dramatic way. In United States v Karl Brandt et al (in US Adjutant Generals Department, Trials of War Criminals Under Control Council Law No 10 [October 1946-April 1949]) it was revealed that horrific crimes had been committed against humanity in the name of science. Doctor Andrew Ivy, a consultant
and expert witness, criticised the research that had been carried out in terms of its design, relevance and extreme cruelty. What was particularly concerning was that this happened despite the fact that in 1931 Germany had put into place strict guidelines to regulate research and these guidelines had remained in place during the time of the Third Reich (Faden & Beauchamp, p.154). Prosecutors also contrasted the conduct of the Nazi experimenters with the American Medical Association standards. Although these events were largely to do with research, the public was alerted about the issue of informed consent and their long held unequivocal trust in physicians and governments was shaken (Brazell, 1997). Despite this, the subsequent impact of the Nuremberg trials on medical research was not great. Rothman (1987) states that "American researchers and physicians apparently found Nuremberg irrelevant to their own work" (p.1197).

2. In 1960, in Seattle, Belding Scriber, developed a permanent indwelling atreiovenous shunt and cannula to be used in kidney dialysis. This meant that, suddenly, doctors were able to keep alive thousands of people who would previously have died of renal failure. The discovery, however, led to ethical problems, as there were far more potential patients than could be treated. Consequently the Admissions and Policy Committee was formed in 1961 to make decisions about allocation of resources. The committee was largely comprised of lay members and so for the first time there was public input into medical matters. All prospective patients would benefit medically from treatment and so the lay committee relied on non-medical criteria, such as social status, finances, support networks and personality, when deciding who should receive treatment. Rothman (1991) described it like this: "a group of physicians, in unprecedented fashion, turned over to a lay committee life-or-death decisions prospectively and on a case-by-case basis. A prerogative that had once been the exclusive preserve of the doctor was delegated to community representatives" (p.150-151). Scriber had "made public a moral dilemma which hitherto had been discussed only privately among physicians" (Pence, 1995, p.299). Journalists were quick to name the committee the "God-committee".

3. Another important event occurred in 1966 when Henry Beecher published an article in the New England Medical Journal in which he outlined twenty-two research
studies which he claimed were unethical. He said that participants had been entered into trials without their knowledge or consent. He highlighted the importance of informed consent in research:

The statement that consent has been obtained has little meaning unless the subject or his guardian is capable of understanding what is to be undertaken and unless all hazards are made clear. If these are not known this, too, should be stated. In such a situation the subject at least knows that he is to be a participant in an experiment (p. 1360).

Beecher, obviously not a Utilitarian, refuted the idea that consent may not be necessary if it proves that the experiment revealed useful data. He said "an experiment is ethical or not at its inception; it does not become ethical post hoc - ends do not justify means" (p.1360). Writing some twenty years later Rothman (1987) claimed that Beecher's study was "a critical element in reshaping the ideas and practices governing human experimentation" (p.1195).

4. Another event which caught the public attention was the first heart transplant carried out by Doctor Christian Barnard in the Grotte Schuur Hospital in Capetown, South Africa in 1967. Barnard transplanted the heart of a twenty-five year old woman into the body of a fifty-five year old terminally ill man, Louis Washkansky. Washkansky died after eighteen days to mixed public reaction. Questions were raised about the definition of death, about quality of life and about the conflicts of interests in transplant teams. Again, discussion of ethical issues had entered the public arena (Jonsen, 1993).

5 The Tuskegee Study: This study had begun in 1930 and continued for some forty years. The study involved four hundred poor and largely uneducated African American men with syphilis. The men were not told that they had syphilis nor were they given any treatment despite the discovery of effective treatments during the course of the study. They were also coerced into participating by the offer of inducements such
as free transportation, hot food, free medicine for other conditions and even free burials. The story was eventually published in American National newspapers in July 1972. The study, which represented a huge cover up by the Public Health Service, alerted the American public to the fact that all was not as it should be in medical and scientific circles. The Tuskegee study had been reported repeatedly in medical journals but no journal editor or physician had ever questioned it (McNeill, 1993).

6. Ethical issues were again brought before the public's attention in 1975 when the parents of a young women, Karen Anne Quinlan, asked the Jersey Supreme Court for permission to disconnect the ventilator that was keeping their daughter alive and allow her to die. Karen was in a persistent vegetative state and her parents were convinced that she would never regain consciousness. Karen's doctors and the hospital had refused to disconnect the ventilator. Her case was the first legal case about life support and it brought the issues posed by new technology into the open. It also raised questions about privacy and surrogate decision making. This case was followed by a series of other similar cases (Pence, 1995).

Callahan claims that "bioethics is a native-grown American product" (in Jonsen, 1993, p. S3) but, even if this is true, it became a New Zealand product as well as a result of the events that happened at the National Women's Hospital in Auckland and the subsequent Cartwright report which followed. In fact, Campbell (1991) claimed that "a side effect of the Cartwright report has been a serious attention to ethical theory and practice well in advance of that in many other countries" (p.36). In June 1987, in an article by Sandra Coney and Philida Bunkle, the New Zealand popular magazine, Metro, published allegations that a research program had begun in 1966 at the hospital in which women with known carcinoma-in-situ (CIS) of the cervix were not being appropriately treated. Public response was dramatic and immediate. The magazine went on sale at the end of May and by 10 June the Minister of Health had established a judicial inquiry, headed by Judge Sylvia Cartwright, to investigate the claims. As Cartwright herself commented in her report, "an article in a non-medical magazine achieved in a few days what the medical establishment could not" (Report, p.131). It transpired that since the 1960's, Doctor Herbert Green, the Associate Professor of
Obstetrics and Gynaecology, had been withholding orthodox and medically accepted treatment from women whom he diagnosed as having CIS in the belief that it would not progress to full invasive carcinoma of the cervix. The usual treatment at that time was to eradicate CIS by cone biopsy and then continue to check that the women had negative cervical smears. At National Women's Hospital women with positive PAP smear tests were observed and retested over a period of many years and left untreated. This was done without the women's knowledge or consent. The head of the Postgraduate School of Medicine at Auckland University and chairperson of the hospital ethics committee, Professor Bonham, was aware of these experiments and stated that they had become such an established part of the routine management of patients at the hospital that Green's experiment had "merged into general treatment". Sandra Coney (1988) described Green as a "man with a mission" (p.51). In the inquiry Judge Cartwright found that many women had in fact gone on to develop invasive carcinoma and that some had died. Further claims were made at the hearing including allegations that vaginal smears had been taken from over 2,000 new born babies without the consent of their parents and that students had conducted vaginal examinations on anaesthetised women and had practised inserting and removing intrauterine devices, again without the consent of the women concerned (Takach, 1995).

Judge Cartwright was scathing in her report of those senior physicians at National Women's, and also the international gynaecological community, who were aware of Green's experiment and yet did little to stop it. She said:

The fact that they did not know they were in a trial, were not informed and that their treatment was not conventional and received little detail of the nature of their condition were grave omissions. The responsibility for these omissions extends to all those who have approved the trial, knew or ought to have known of its mounting consequences and its design faults and allowed it to continue...in failing to intervene, the medical profession failed in its basic duty to its patients. (Report p. 69-70).
The impact of the events at National Women's were far reaching with many realising that the implications for patients went far beyond the "unfortunate experiment" itself. Corbett, (1990) expressed it like this:

The issues at the heart of this inquiry are not unique to National Women's Hospital. They are not limited to a period of time somewhere in the past. Ultimately the issues are about who controls medicine and how; about who benefits from it and who are its victims. Thus, as so many witnesses have so clearly stated, the central issue, above all others, is power. (p. 62)

Writing in 1988 Charlotte Paul, who served as one of the medical advisers to Judge Cartwright on the inquiry, stated that "the ethical issues raised by the inquiry go beyond the specific difficulties in one institution to the underlying problem of accountability in medicine"(p.533).

Judge Cartwright also recognised this and in her report recommended that patient advocates be appointed to each New Zealand hospital to ensure that patients have the opportunity to consent to all procedures that they undergo. This, however, was to be just the first step. It was obvious that new consent procedures would be needed. In the past, as Paul (1988) points out, patients were safeguarded by the integrity of the doctor but "when that good faith is brought into question at the highest levels in the hospital there must be recourse to other mechanisms to protect the patient" (p. 538). Consequently the Judge also recommended that the New Zealand Human Rights Commission Act 1977 be amended and a Commissioner be established to "define, monitor and protect patients rights" (Report, p. 214). Other recommendations of the report were that a national cervical cancer-screening programme be established; national guidelines for review of research and treatment protocols be set up; changes be made to medical education to improve knowledge of ethical guidelines for treatment and research and to improve communication skills.

There was considerable rejoicing at the time that the Report was published as the campaigners and the women involved felt that a victory had been won and that changes
would be implemented. However in the years that followed many became disillusioned with the slowness of the changes, although the first patient advocate was appointed at National Women's Hospital as early as August 1988.

The Labour Minister of Health, Helen Clarke, finally introduced the Health Commissioner Bill to parliament in September 1990 with a proposed implementation date of 1 May 1991 but a general election intervened and the Labour government was replaced by a National government. The new Minister of Health, Simon Upton, announced that there was to be a major reconstruction of the health sector. As a result of these health reforms the Bill was altered to include disability services and disability consumers. This was in line with other policy changes that were being introduced at that time by the National Government.

There were complaints from women's health groups and others that the original intentions of the Cartwright report were being constantly watered down. Coney (1993) claimed that, because of the length of time that had been allowed to elapse since the report, doctors had been able to influence government and confuse the public about the issues. Indeed several vitriolic letters were published in the New Zealand Medical Journal. Dr. D Purdie (24 October, 1990) claimed that the Cartwright report was the end result of a feminist witch-hunt, which had been overseen by a feminist judge. Dr W. Pryor (25 July, 1990) said:

The fallout from Cartwright will take years to recover from, medical research has been set back by decades, screening programmes costing millions and of doubtful value have been embarked on, unworkable consent forms have been produced and majority lay committees can decide on treatment protocols.

(p.355)

The Health and Disability Commissioner Act (herein after referred to as the "Act") was finally enacted in October 1994 and the first Commissioner, Robyn Stent, appointed in December 1994.
The Act has a wide coverage and includes both public and private providers of both health and disability services, regardless of whether or not those services are being paid for. It applies to all health and disability providers and not just health care professionals. It also applies to Crown agencies delivering services. The legislation is unique to New Zealand in that:

1) The rights are codified into regulation
2) The complete process is covered which assists lowest level resolution
3) Their role is to empower the consumer.
4) It applies to both the public and private sectors
5) It covers both health and disability consumers
6) It has the ability to interface with both disciplinary and other rights tribunals.

It is important to note that the Act is about the quality of service provision and not about the quantity of provision. Consumers have wide ranging rights under the Act but do not have the right to treatment, *per se*. The Commissioner stated clearly in the Proposed Draft Code that the Act and the Code do not address which services are to be purchased by public funds (p.8). These decisions are to be made by the State, the Health Funding Authority, the ACC or other government agencies.

The stated purpose of the Act is to "promote and protect the rights of health consumers and disability service consumers, and, in particular..., to secure the fair, simple, speedy and efficient resolution of complaints relating to infringements of those rights ..." (Long Title). Grievances and complaints are to be heard by the Commissioner with a view to resolution by negotiation, mediation and education rather than by resolution through the Courts. The aim of this low level and informal resolution is that it prevents further stress to the complainant, it is of low cost, it preserves client privacy and it allows the parties involved to determine when resolution has been reached. One possible disadvantage of this system is that, in failing to involve the Courts in the interpretation of the law, helpful precedents are not created. Another problem, identified by some professional bodies, is that complaints often do not reach the
professional body concerned and so they are not aware of problems which are present within the profession that may need to be addressed. There is also concern that the Commissioner, who has neither a legal nor a medical background, may fail to understand the significance of some complaints. To some extent this problem may be addressed as the Commissioner now publishes copies of the cases that have been dealt with for the purpose of educating both the public and the health care sector (Townshend, Sellman, & Haines, 1998).

The Act is in five parts as follows:

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<th>Part</th>
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<tr>
<td>I</td>
<td>Health and Disability Commissioner</td>
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<tr>
<td>II</td>
<td>Code of Health and Disability Consumers' Rights</td>
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<td>III</td>
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<td>V</td>
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Sections 2, 3 and 4 give the various definitions that are particularly important in deciding rights. Of particular importance are the definitions of "health consumer" and "disability consumer". A health consumer is defined as including any person on or in respect of whom any health care procedure is carried out. A disability services consumer means any person who has a disability that reduces their ability to function independently and which means that that person is likely to need support for an indefinite period.

The Act also provides separate definitions of "health care provider" and "disability services provider" in sections 2 and 3. In both the case of the consumer and the case of the provider the definitions are extensive. Skegg (1997) says "as a result of some of the broad definitions provided in the Act, the Code has a much more extensive application than is apparent from the Code itself" (p.128). Of importance to physiotherapists is that under s 4(1) they are defined as health care providers as are physiotherapy students working under the supervision of a registered physiotherapist (s 4(2)). Another point to
Clause 4: Establishes certain definitions and elaborates on some of the definitions of the Act

Clauses 5 & 6: Note that in meeting the rights no provider is required to break any other New Zealand law.

Clause 1 of the Code states clearly that "consumers have rights and providers have duties". The Commissioner states that both providers and consumers raised the issue of consumers' responsibilities during the consultation process. However the Act required the Code to establish consumer rights and provider duties and therefore this is what has been done (Proposed Draft p.14). As the Code is a Code of **Rights** there is no mention of the corresponding responsibilities of consumers. There are those who would see this as a regrettable omission. Faulder (1985) says that rights do bring responsibilities and "we must accept that in claiming our right to be informed we (*patients*) too will have to shoulder new responsibilities because rights entail obligations, both on those who claim them and on those from whom they are claimed" (p.41). For the relationship between the consumer and the health care provider to be equal and just then the consumer needs to confide in the provider every bit as much as the provider discloses information to the consumer. Coy (1989) reminds us that if we are to fully embrace this autonomy-enhancing behaviour then there will have to be "perceptual shifts, not only among those who provide health care but also among those who receive it" (p.830).

The Code is unique in that it reduces the distinction between legal and ethical standards (Right 4(2) and Right 6(1)(e)). People now have the right to have services provided which comply with ethical standards.

Clause 1 (3(a&b)) states that providers have a duty to inform consumers of their rights as set out in the Code, and to enable them to exercise their rights. It seems that physiotherapists initially did well in this area. A survey carried out in June 1996 to assess provider awareness of the Code showed that there was the highest level of awareness among physiotherapists - 76%. This compared with nurses at 72%, general practitioners at 46% and dentists at 19%. However, when the survey was repeated in 1997, a year after its implementation, only 57% of physiotherapists said that they were
aware of the Code. This compared with 100% of midwives and 89% of nurses. During the same twelve-month period the Commissioner reported that she had investigated ten complaints against physiotherapists although none had proceeded to further action. In the 1998 provider awareness survey physiotherapists’ awareness had risen slightly, to 64%. However in this period the Commissioner received eleven complaints involving physiotherapists and in one case the Commissioner’s opinion was that there had been a breach of the Code (Report on opinion – Case 97HDC4720). She has decided to refer the matter to the Director of Proceedings. This case will be discussed further in chapter 4.
Chapter 4: The Code of Health and Disability Services
Consumer’s Rights and the practice of physiotherapy

Clause 2 of the Code sets out the ten rights of consumers and the duties of providers in respect of those rights. In some senses it could be argued that there are many more than ten rights as each right details others. However, it could also be claimed that there are no rights at all because Clause 3 of the Code provides a potential qualification to the rights in the Code. Consequently, before there can be any discussion of the individual rights the implications of clause 3 will be discussed.

CLAUSE 3

Clause 3 is headed “provider compliance” and states that "a provider is not in breach of the Code if the provider has taken reasonable actions in the circumstances to give effect to the rights and comply with the duties" in the Code. This clause was inserted because the Commissioner recognised that there would be occasions when providers could not be expected to give effect to all the rights in the Code. In the text accompanying the Proposed Draft Code she said "In an ideal world providers would give full effect to all the rights of consumers. However, in reality no provider is able to do this and unless some reasonable limits are in place, providers will continually be in breach of the Code" (p.48). In setting a general limitations clause the Code follows the model of the New Zealand Bill of Rights Act 1990, rather than that of the Health Information Privacy Code which sets specific limits on each of the individual rights. It is unclear by what, or whose, standards ‘reasonableness’ will be assessed although initially this will be taken as what is reasonable in the view of the Commissioner and also that of the Complaints Review Tribunal if the matter comes before them. The Commissioner points out that the standard of reasonableness may change over time (Proposed Draft Code, p.49). Acceptable reasons for failing to comply with the Code are given (Clause 3(3)). These include the consumer’s clinical circumstances, the provider’s resource constraints and any other relevant circumstances.
Looking at resource constraints, the Commissioner was of the opinion that if she did not set limitations in the Code they would be set in any case by Courts and Tribunals. She also believed that a Code which recognises reasonable limitations would encourage provider compliance. However, the onus will always be on providers to demonstrate that they took reasonable steps to give effect to the rights (Clause 3(2)).

In the last thirty years costs in health care have escalated. There are several reasons for this - people are living longer and the over sixties now consume over 40% of the health care budget; advances in technology have meant that there are ever increasing possibilities, and new technology is often expensive; communities expectations have risen. Governments must make decisions on a macro allocation level in deciding how much to spend on health compared with, say, education or defence. Decisions must then be made about how much of the health care budget should be allocated to each service, for example how much should go to child health and how much to cardiac services.

The Core Services Committee addressed the issue of fair allocation of resources in New Zealand. They stated that money should be directed to those services which:

- Show good evidence of benefit so that people who stand to gain the most have the greatest priority. In this way resources are used to achieve the greatest effectiveness.
- Are a fair use of resources compared with other ways of spending the money, on this person or another at another time. In this way resources are used to achieve the greatest equity.
- Are consistent with the values of the community. In this way resources are used to achieve the greatest acceptability.
- Are the best value for money in cases of two or more similarly effective ways of managing a condition. In this way resources are used to achieve the greatest efficiency. (Core Services Committee: The Best of Health 2, 1993)

The autonomous physiotherapist has to assume responsibility for the just and fair allocation of resources within physiotherapy services. The physiotherapist is now free
to set his or her own policies about who to accept for treatment (within the limits set by
the Human Rights Act), how to establish priorities between them and at what level to
set fees for services. As has already been noted this increased freedom brings new
ethical dilemmas which the physiotherapist must resolve. Consider the following case:

Case 4:

A patient telephones a physiotherapist working in a private practice requesting
an urgent appointment. The physiotherapist has treated this patient before and
he still has an outstanding account with her. She explains that she is very busy
and gives him the telephone number of the hospital physiotherapy department
where treatment is available without cost. However, later in the morning, the
patient rings back and says that he has found it impossible to get an appointment
at the hospital. He claims that he is acute pain, and asks the physiotherapist to
see him.

The physiotherapist can no longer just refer the patient back to the doctor but has to
decide for herself how to proceed. She can choose to treat the patient and risk another
unpaid bill or she can refuse to treat him on the grounds that he is a poor payer. She
may also have to cancel someone else's treatment in order to fit him in.

World wide there is an increasing demand for physiotherapy services but in many
places this is matched by a decreasing willingness by the governing powers to pay for
them. Also as more physiotherapists enter private practice they may meet patients who
also experience lack of resources and may be unable to pay for treatment.
Physiotherapists must become involved at a policy making level to ensure adequate
representation of physiotherapy services. More radically some have suggested that it is
the duty of professionals to contribute some working hours each year without any
expectation of financial reward (Lunberg & Lawrence, 1987). Although a whole health
system cannot be run in this way “the professional ethic has long held that one
characteristic of a true profession remains its special relationship with the poor”
(Purtilo, 1988).
Despite the fact that resource allocation is cited in many surveys (Guccione, 1980; Triezenberg, 1996; Barnitt, 1996) as a problem for physiotherapists there has been little guidance on the matter in physiotherapy journals. An American author, Ruth Purtilo, in articles written in 1979, 1981, 1988, and 1992 discusses the issue. In Great Britain the Chartered Society of Physiotherapy has issued an information paper called "Rationing of Physiotherapy Services". There have been no articles on this subject in the New Zealand Journal.

Clause 3 must be kept in mind during the following discussion of the individual rights. It should also be noted that the Code cannot be understood in isolation but must be read in conjunction with the Act which provides crucial definitions and the steps which can be taken following an alleged breach of the Code.

RIGHT 1: The right to be treated with respect

In a seminar presentation given in 1998 the Commissioner stated that the right to respect, as outlined in Rights 1, 2 and 3, is the cornerstone of the Code and it is not coincidental that respect itself is listed as the first of the rights. She said that these three rights form an “attitudinal umbrella” under which all services must be delivered. (Unravelling the Code. Presentation to the Marie E. Burgess Seminar, “Getting it right – managing risk for health professional”, April 1998)

Right 1(1) states that the consumer has the right to be treated with respect. What does this mean in practical terms? John Carmody (1994) described his personal experience of the physiotherapy treatment that he received from two very different practitioners. Carmody, suffering from multiple melanoma, had undergone surgery to insert a metal rod into his leg and then needed physiotherapy treatment to assist in his mobilisation. He describes the first physiotherapist as a domineering woman who, disregarding his pain and weakened state, “bullied” him during treatment. He says that he had "no say in the matter" and graphically describes how he would end each treatment session
dripping with sweat and "furious at the woman's not-so-subtle insinuations that I was a coward" (p.35). He claims that she completely disregarded the fact that he was both an educated man and a lifelong athlete with a great will to recover. She treated him as if he was stupid and also as if he was malingering. Fortunately for Carmody, and also for the reputation of the physiotherapy profession, another physiotherapist was involved in his care. She encouraged, prompted and praised and answered all his questions. He says that despite his weakness he felt his confidence improve and he no longer dreaded the sessions. He comments that "what seemed impossible two days earlier now seemed well within my reach. I would walk again, soon and well"(p.36). On reflection Carmody judged that what the first physiotherapist failed to do, in her myopic concentration on the purely physical, was to show him the respect due to a fellow human being. From Carmody's account it would seem that in order to treat a patient with respect one thing that the physiotherapist, and all other health care professionals, must endeavour to do is to see each patient as a unique individual with particular needs and aspirations. Indeed, in their advice to physiotherapists working with patients in a neurological setting, Corr and Corr (1986) say that "respecting the patient as person calls upon us to regard patients as unique individuals and to see them in the totality of their being, with physical, psychological, social and spiritual dimensions" (p.23).

Right 1 also encompasses the right of a consumer to have his or her privacy respected (Right 1(2)). Privacy in the context of the Code refers to physical personal privacy as privacy regarding health information is dealt with by the Privacy Act 1993 (NZ) and the Health Information Privacy Code 1994 (NZ). (Clause 4 of the Code defines privacy as encompassing all matters of privacy in respect of a consumer, other than matters of privacy that may be the subject of a complaint under Part VII or Part VIII of the Privacy Act 1993 or matters to which Part X of that Act relates).

Right 1(3) requires that consumers be provided with services that take account of different value and belief systems. This statement applies to all consumers, whatever their country of origin, however, the statement also makes specific reference to the needs, values and beliefs of Maori. In the late 1980's the concept of cultural safety was developed in New Zealand by a group of Maori nurses in order to analyse nursing
practice from their perspective as members of an indigenous minority (Polaschek, 1998). It has since been adopted as part of the basic curriculum of nursing training and is also being incorporated into the training courses of other health disciplines. The 'safety' in the term 'cultural safety' is meant to describe practice that meets an adequate ethical standard, from the perspective of the client. Health care which are unsafe are those which demean, disempower, diminish or threaten the cultural identity and well being of an individual. Conversely, Wood and Schwass (1993) say that safe practice involves "actions which recognise, respect and nurture the unique cultural identity of the Tangata Whenua, and safely meet their needs, expectations and rights" (p. 5-6).

In order to practice in a culturally safe manner the physiotherapist must recognise that individuals must not be stereotyped because of the ethnic group to which they belong. While culturally safe practice is practice which recognises and addresses Maori, Pakeha and other perspectives, practitioners must make a special effort to understand the inadequacy of the health service for Maori and the nature of the social structures which alienate them. In specifically mentioning Maori in Right 1(3) it would seem that the Code endorses this view. Practitioners must seek to promote Maori health and provide services that take account of the "needs, values and beliefs of Maori". We must also recognise that some Western ideas need to be reappraised in the context of other viewpoints. For example, independence and autonomy are not meaningful concepts in those cultural groups in which identity is collectively determined through relationship to family, the larger sociocultural group and to the land itself. This provides a challenge for providers as the whole Code, with its emphasis on individual rights, is an expression of the Western individualistic approach.

Most professional bodies already have codes of practice which incorporate these values and physiotherapists are no exception. Clause 3(2) of the NZSP Code states that the patient has the right to expect the physiotherapist to provide "appropriate personal privacy". However, there is no clear statement about respect for the patient or about provision of services in a way that takes account of religious or cultural differences. In order to comply with these rights physiotherapists will need to be particularly careful when asking patients to undress for treatment. Explanations must be given, appropriate
dresses used and the opportunity given for questions. Sensitivity will also be needed when treating people from different cultural backgrounds. Physiotherapists also need to develop better cultural awareness and a greater understanding of the Maori view of health and the Treaty of Waitangi. The broad concept of the Treaty, a socio-political document rather than a legal document, is that it is a reciprocal bargain whereby "Maori ceded rights of government in exchange for guarantees of possession and control of their lands and precious possessions" (New Zealand Maori Council v Attorney General [1987] 1 NZLR 641 at p. 702). Although there is little provided in the Treaty by way of its application it has been held by the Court of Appeal that central to the partnership created by the Treaty is an obligation of good faith and an obligation to work out answers in a spirit of honest cooperation (New Zealand Maori Council v Attorney General [1987] 1 NZLR 641 at p. 664-667 per Cooke, P. at p. 682 per Richardson, J.)

Many physiotherapists spend a great deal of time working with the disabled. The statement in the Code that privacy should be respected applies equally to the disabled. This poses a challenge for all health care providers. Erosion or total loss of privacy figures prominently in the daily lives of many people with a disability. Even basic rights concerned with privacy in bathing and toileting may be lost. Doors may be left open, screens or curtains not pulled and patients made to wait for long periods of time. One woman with a disability said that sometimes health care professionals are so concerned about the "problem" - the disability - that privacy "flies out of the window, automatically taking with it dignity, self-esteem, respect and much else - sometimes sanity and the will to live" (Brown, 1994, p.116). The challenge for the physiotherapist working with such people is to be sensitive to the fact that although help with personal cares is routine for some of the disabled they deserve as much consideration, as far as their privacy is concerned, as the able bodied. One physiotherapist, in the survey conducted by Barnitt (1998) gave the following example of a patient whose privacy and dignity was not being respected:

The patient was walking round the ward and in the public areas with a urine bag on a stand. Usual practice was for mobile patients to have a leg bag and I asked
the ward for one but was told that they didn't have one and that the patient was too confused to notice. (p.195)

If it was indeed true that a leg bag was unavailable, and if the staff concerned could show that they had made reasonable efforts to procure one, then it seems that if the patient made a complaint under the Code the provider would be able to show that it took reasonable actions, in the circumstances, to give effect to the patient's rights (Clause 3(2)). The staff might also claim, although this seems less easy to defend, that the client's confusion and inability to realise that his dignity was threatened would constitute relevant "clinical circumstances". The reason that this might be harder to defend is that it would mean that all unconscious, confused, disorientated, intellectually disabled, very young or very old patients could be treated without regard to their dignity, and this is quite contrary to the purpose of the Code.

Sometimes physiotherapists, like other health care professionals, encounter patients who are abusive, rude or difficult. It is interesting to consider how much respect is due to such clients. Popular opinion may support the view that, to some extent at least, respect has to be earned. However, the Code, which makes no mention of provider rights in such circumstances, still requires that all consumers be treated with respect. However, providers are not in breach of the Code if they take actions, which, in the circumstances, are reasonable (Clause 3(1) and (3)). In a recent case considered by the Health and Disability Commissioner it was the Commissioner's opinion that it is the responsibility of a medical practitioner, and by implication any provider of health or disability services, to remain calm and behave professionally with patients "no matter how difficult the consultation" (Report on opinion – Case 97HDC6528).

RIGHT 2: The right to freedom from discrimination, coercion, harassment and exploitation.

The right to be free of discrimination means the right to be free of discrimination that is unlawful by virtue of Part II of the Human Rights Act 1993 (Clause 4). While this right
is already provided by the Human Rights Act and, to some extent, by the New Zealand Bill of Rights Act 1990, due to the large number of submissions received on this subject it is specifically included in the Code. "Exploitation" includes any abuse of a position of trust, breach of fiduciary duty, or exercise of undue influence (Clause 4). We have already seen (In Cases 1 & 2 on pages 39 & 40) how easy it can be for a physiotherapist to coerce or harass a patient when seeking to obtain informed consent. However, this is not the only situation when exploitation can occur. Of particular importance in physiotherapy practice is the potential for sexual exploitation.

Sexual conduct

The NZSP Code of Ethics (Code of ethical principles – a discussion document. New Zealand Society of Physiotherapists Inc.) has three statements under the heading “Responsibilities to the patient”. Two of these are relevant to Right 2 of the Code. Part 1.1 states that the relationship between the physiotherapist and the patient is one of trust and must never be abused and the second is that “a physiotherapist shall never enter into a sexual relationship with a patient” (1.2). One might ask why the issue of sexual relationships is given such prominence in the NZSP Code when it is only mentioned in the Code of Health and Disability Services Consumer's Rights as part of Right 2. "Every consumer has the right to be free from discrimination, coercion, harassment and sexual, financial, or other exploitation". This issue is important to a profession which is primarily a handling profession and in which almost all treatments involve touching, often with the body of the patient and that of the physiotherapist in close proximity (see fig. 2, page 53). Physiotherapists handle patients when examining, testing muscle strength and joint range, when positioning, stabilising and instructing and when using many treatment modalities including massage, manipulation and mobilisation techniques. This handling and touching must be carefully explained to the patient to prevent misunderstanding and misinterpretation that could lead to embarrassment for the patient and even possible legal action. In the past few years the Disciplinary Board of the New Zealand Society of Physiotherapy has dismissed several members for
unprofessional conduct in this area. In one case the disciplinary board reported that the physiotherapist formed and maintained "an inappropriate sexual association with a patient" for a period of three years. In suspending the physiotherapist the Board commented that it was mindful of "the ethical duties" of the physiotherapist and the "strong public interest in the maintenance of professional standards". As a response to this, the Board has published a number of guidelines for physiotherapists. These guidelines state that there are several degrees of sexual misconduct:

**Sexual impropriety:** This means any behaviour, including gestures and expressions that are sexually demeaning to a patient, or demonstrate a lack of respect for the patient's privacy. This could include things such as inappropriate draping or undressing, making inappropriate comments about the patient's body or underwear or asking for irrelevant details about sexual orientation or performance.

**Sexual transgression:** This includes any inappropriate touching of the patient that is of a sexual nature.

**Sexual violation:** This refers to any sexual activity between the physiotherapist and the patient whether or not it was initiated by the physiotherapist.

(Professional sexual abuse policy – a discussion document. New Zealand Society of Physiotherapists Inc.)

An important point is that while consent, in any of the situations described above, may make the conduct legal it does not make it ethically acceptable. The NZSP Code states that "consent by the patient/client is never a defence". Consequently physiotherapists are advised to preserve the boundaries in the professional relationship and warned that the breaking of the boundaries is often insidious. They must be alert for the warning signs that boundaries are being blurred. Boundary violations include the following:
1) Time boundaries: These occur when the physiotherapist makes appointments for the patient at unusual hours, where there is not therapeutic or practical necessity.

2) Place boundaries: The physiotherapist should, whenever possible, treat the patient in the hospital ward, physiotherapy department or private practice rooms. Physiotherapists who treat patients in their own homes need to be particularly careful that this is necessary and that, whenever possible, other people are present in the home.

3) Receiving gifts: This has the potential for abuse and can arise in any health care professions. Gifts can be given in order to manipulate the physiotherapist, to "buy" favours such as quicker or more frequent treatment, because the patient sees it as an obligation or as a simple "thank-you" for care received. Physiotherapists should be careful if gifts are inappropriate in terms of size or if they are of a personal nature.

4) Dress boundaries: Increasingly physiotherapists do not wear uniforms, even when working in a hospital setting. Care needs to be taken to ensure that clothing is appropriate.

5) Self-disclosure boundaries: Revealing personal information to patients can send false messages and allow the patient to think that intimacy is appropriate and is being encouraged.

6) Physical contact boundaries: As previously discussed this is an area of potential difficulty for the physiotherapist. Consequently all care must be taken to ensure that the patient understands the nature of any touching that takes place, the reason for it and then gives their consent to it.

In a case of alleged sexual exploitation, heard by the Complaints Review Tribunal in 1998 (CRT 13/98), there are examples of boundary blurring. The doctor telephoned the
patient at her place of work, appointments for consultations were made out of usual office hours and there had been an exchange of gifts.

Until recently the New Zealand Medical Association had a standard of "zero tolerance" concerning sexual relations with existing or former patients. However in 1997 the rules were relaxed somewhat and it became acceptable for doctors to have a relationship with a former patient, under some circumstances, such as when the relationship had developed as a result of social contact away from the professional environment. In writing the Physiotherapy Sexual Abuse Policy the committee did not use the words "zero tolerance" but nevertheless accepted that "it is fair to say that most of the material in this discussion document is entirely compatible with that produced by those who do find that term (zero-tolerance) convenient terminology" (p1). However, the guidelines themselves do seem to accept the possibility of a sexual relationship with a former patient. Several factors may need to be considered in determining how much time must elapse before entering into a personal relationship after terminating the therapeutic relationship. These might include the length and nature of the professional relationship, the amount of personal disclosure that has occurred and the degree of dependency that was involved.

At the 1994 Annual General Meeting of the New Zealand Society of Physiotherapy a "short life" working party was set up to develop a policy on professional sexual abuse. The resulting document was circulated to members in December 1994 and adopted by the Society as policy at the Annual General meeting in 1995. In August 1996 all members of the New Zealand Society of Physiotherapy were sent a survey about sexual contact in the professional relationship. The two purposes of the survey were to see how the policy was being applied in practice and also to get a picture of what physiotherapists thought was appropriate in this area. 1,365 members, a response rate of over 90%, completed the survey so it is likely that the responses are an accurate reflection on the attitudes of the profession (Cullen, Davidson & Guthrie, 1997a).

The significant findings of the survey were that over 40% admitted to having felt sexually attracted to a patient and about 25% reported having dated one. More
significantly, 102 (7.5%) physiotherapists admitted to having had sexual contact with a current or former patient. These physiotherapists were more likely to be male (10.9% as opposed to 6.6% of females), and aged between 30 and 36, and working in rural practices (Cullen, Davidson & Guthrie, 1997b).

The emphasis of the survey was on the behaviour of physiotherapists but one question asked whether any of the respondents had been sexually propositioned or harassed by a patient or their relative. Over 40% responded in the affirmative to this question. In a survey carried out in Canada, which included students as well as qualified practitioners, 80% of respondents reported that they had experienced some level of inappropriate sexual behaviour from patients (McComas, Hebert, Giacomin, Kaplan & Dulberg, 1993). This study was recently repeated in Australia with similar results (Weerakoon, & O'Sullivan, 1998). While the Code seeks to protect patients from inappropriate sexual advances from physiotherapists and other providers it is unable, because of its “patient rights” emphasis, to offer similar protection to providers. The authors of each of these surveys stressed the need for this subject to be discussed in the literature and for more education to be given to better equip physiotherapists to deal with this problem. However, other than the reports of the three surveys already mentioned, this subject has not been discussed in the physiotherapy literature, despite also being identified by Triezenberg (1996) as an issue of concern.

The issue is also obviously of concern to the general public. Just after the results of the New Zealand survey were published in the New Zealand Journal of Physiotherapy a local newspaper picked up on the article and reported it under the heading "No sex please we're only physiotherapists". The piece went on to suggest that physiotherapists were offering their patients "a little more service than expected". (Otago Daily Times, 15 January 1998).

The first, and to date the only, Code of Rights case to go to the Complaints Review Tribunal dealt with the issue of sexual exploitation. The case, in which the consumer alleged a breach of Rights 2, 4(2) and 4(5) of the Code, involved a complaint made about a General Practitioner. The tribunal found that the doctor had breached these
rights despite the fact that the sexual relationship was consensual, the patient had initiated some of their meetings and it was the doctor who had terminated the relationship (CRT 13/98).

Financial exploitation

Right 2 also establishes the patient’s right to be free from financial exploitation. This type of exploitation could occur in physiotherapy in several ways. Firstly, and most obviously, fees in private practices can be set at too high a level. This is less likely in major centres where there is more than one such practice and consequently greater competition. The more insidious way in which financial exploitation can occur is that, as part of their treatment of patients, physiotherapists frequently recommend that patients wear a surgical support of some description. Such appliances include wrist splints, back braces, knee supports and many others. They may also use, and recommend, anti-inflammatory gels. If physiotherapists are working in a private practice setting they will probably have these products and appliances available to sell to the patient. The advantage to the patient is that the physiotherapist can ensure that the device is fitted correctly and also save the patient the inconvenience of having to visit a pharmacist or other supplier. The danger is that the physiotherapist might be tempted to sell products to patients which they do not need in order to make an easy profit or to sell to an unsuspecting patient a more expensive device than they need. Such behaviour would clearly be exploitation and an abuse of the physiotherapist’s position of trust. It would also be in breach of principle 7.1 of the NZSP Code that says, “physiotherapists shall not engage in any conduct that is misleading as to the nature, characteristics or suitability for a purpose of a product or service”.

The Commissioner gave a similar opinion in a case involving a chiropractor (Report on opinion - Case97HDC4373). The chiropractor gained information about the patient in the course of treatment and then used the information to contact the patient at home and try to involve the patient in a business scheme. The Commissioner found the chiropractor to be in breach of Rights 2 and 4(2) of the Code.
In another case involving financial exploitation reported in the New Zealand Medical Association newsletter (22 January 1999) a doctor charged a patient more than he originally quoted when he discovered that the third party payer was prepared to reimburse him at a higher level. The Commissioner took the view that the doctor had breached the NZMA ethical standards (Rule 26) and also rights 4(2) and 6(1) of the Code by charging a higher fee to a consumer with health insurance than he would a consumer without it. The matter has also been referred to the Director of Proceedings who will decide if any further action is required. Physiotherapists who work in private practice frequently treat patients with private health insurance and should take note of this judgement.

It was stated at the beginning of this chapter that the provisions of Clause 3 provide a potential qualification to the rights in the Code. However, it is difficult to think of any situation where the right to freedom from “discrimination, coercion, harassment and sexual, financial or other exploitation” could be limited by either resource constraints or clinical circumstances, or indeed, by any other circumstances.

RIGHT 3: The right to dignity and independence

Right three states that every consumer “has the right to have services provided in a manner that respects the dignity and independence of the individual”. Dignity has long been considered a fundamental human value. The Universal Declaration of Human Rights adopted by the General Assembly of the United Nations in 1948 states in its first Article that "all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood." This right raises a fundamental question - what does the Code mean by dignity? A search of the medical literature revealed very little on the subject if those articles dealing with death and dying were excluded. Only three articles attempting to discuss the actual concept of dignity were found - Mairis (1994), Haddock (1996) and
Shotton and Seedhouse (1998). All were in nursing journals. Dignity is rarely defined and it tends to be something that we recognise more easily when it is absent.

The word 'dignity' is derived from the Latin 'dignus' which means worthy. The Collins Concise Dictionary (1989) gives five definitions of dignity: 1. A formal, stately or grave bearing, 2. The state or quality of being worthy of honour, 3. Relative importance; rank, 4. Sense of self-importance, 5. High rank. Numbers 2 and 4 seem to capture the essence of the word as it applies in the health care setting. Physiotherapists, and other health care professionals, need to restore to patients their sense of their own value and worth and to recognise them as being worthy of respect or honour by virtue of their humanness. In fact any action that undermines a person's feeling of self-worth is degrading and shows lack of respect for patient dignity. According to some philosophers human dignity is based on the fact that humans do not just exist unconsciously but are self-conscious.

The concept of dignity seems to be closely related to issues of respect, privacy, autonomy, control and choice. Mairis (1994) states that "dignity may be said to exist when an individual is capable of exerting control or choice over his or her behaviour, surroundings and the way in which he or she is treated by others" (p.952). Those particularly vulnerable to loss of dignity are those such as the mentally ill, the elderly, the frail and the comatose, who are incapable of self-advocacy.

In their submissions to the Commissioner on this subject many consumers also linked dignity and respect. Statements such as "service users are entitled to be treated with respect and dignity" and "the dignity of all must be respected" were common sentiments (Draft Code p16-17). In order to treat patients with dignity and respect health care professionals will need to keep in mind the position of "power" that they hold relative to the consumer (see also Right 2). The consumer may be in strange surroundings, in pain, and to a greater or lesser extent dependent on the health care provider. If the provider keeps this imbalance in power in mind they are less likely to abuse it. The attitude of the provider to the consumer should be one of respect and care for the "human dignity of that patient as a person. And this attitude must prevail in spite
of the fact that the sick person may not even appreciate his /her own humanity" (Thomasma & Pisaneschi, 1977, p.17).

Neither the NZSP nor the British CSP codes have direct statements concerning the need to respect the dignity or independence of the patient. Matters of dignity are perhaps dealt with within more general statements about patients' rights to be treated with respect and without discrimination. These matters are dealt with in the Code (Rights 1 and 2) but it was still considered necessary to include a separate right about dignity. This is probably because in the parent Act the Code is required to include some matters, while others are left to the Commissioners discretion. Section 20 of the Act required that provisions relating to “the duties of health care providers and disability services providers to provide services in a way that respects the dignity and independence of the individual” be included in the Code (20(g)). In Right 3 providers are also required to provide services in a way that respects the independence of the individual. This is not mentioned or referred to anywhere in the NZSP or CSP Codes. Perhaps this is because of the physiotherapist's special relationship with the disabled and dependent. The bald statements of rights, as given in the Code, are unfortunately detached from the original discussions and submissions that gave rise to them. In the Draft Code it is explained that this right "directs the provider to keep in mind that the objective of the service is to optimise independence and quality of life" (p.21 and Right 4(4)). Even though no guarantees can be given as to outcome, the consumer has a right to expect that optimal outcome is an objective of the service. This is a sentiment that all physiotherapists will agree with. However, they would also want to point out that, for many of their patients, their experience is going to be of dependency rather than independence. While they will strive to maximise the independence of the patient with a C4 spinal lesion who is maintained on a ventilator, or the patient who has suffered a catastrophic head injury, they must accept that for them the reality is that their independence is severely limited. Further, there are those in our community, and the long-term disabled surely belong to this group, who will never be fully autonomous or independent. Rather than thinking about how to develop more autonomy we should be considering how to foster appropriate, caring and nurturing dependency (Campbell, 1984). In the latter part of the twentieth century there has been an almost unchallenged
view that self-determination is the pre-eminent ethical principle. As Campbell (1984) has stated we have come to a point where we need to accept that for many people the maintenance of autonomy will not be the major issue. Rather people need know that they are responded to, loved and protected by people that they can trust.

It is also interesting to consider how this right may be restricted by the limitations of Clause 3. In order to maximise the independence of some who are severely disabled, expensive equipment may be required which the provider, because of resource constraint, may be unable to provide. Providers may also claim that the consumer’s clinical circumstances, and therefore their ability to substantially benefit from the equipment, were such that the expense could not be justified. Providers may also claim that the consumer’s clinical circumstances, and therefore their ability to substantially benefit from the equipment or rehabilitation program, are such that the expense cannot be justified. Modern technology has provided the means for preventing the deaths of many of the victims of disease and trauma, and the emergence of the field of rehabilitation medicine has meant that those who survive can be returned to their community, home and family as participating members. In fact, Howard Rusk, one of the pioneers in the field, said that the major achievement of rehabilitation medicine in its first thirty years has been to get doctors to accept that they have not finished with their patients when the “fever is down and the stitches are out” but that there is a moral duty to restore function (Rusk, 1978, p.156). More recently Caplan, Callahan and Haas (1987) have questioned whether doctors and society have actually come to terms with this. They say that it is debatable that they have accepted that those who are “rescued or saved by acute care have a legitimate claim to receive the follow up rehabilitation services that will enhance their capacity to cope with disability” (p.17). It can be argued that the exceptions in Clause 3 support his point of view.

**RIGHT 4: The right to services of an appropriate standard.**

In the past, when considering standards in the health sector, the focus has been on standards of clinical practice and the professionals have set the standards. However in a
more consumer focused environment this is no longer appropriate. The Code provides a framework for addressing standards in a wider context. Again, the Commissioner was obliged to include this right (Health and Disability Commissioner Act 1994, 20(f)).

Right 4(1) states that services must be provided with reasonable skill and care. The Code itself does not define an appropriate standard but in the commentary to the Proposed Draft Code it is taken as including a "safe environment and competent, trained providers" (p25). It is stressed that standards will be primarily measured against patients' needs. In the NZSP Code there is a whole section concerned with standards of care. The first point that is made is that physiotherapists must only practice in those areas in which they are competent (2.1) and that if a patient presents with a problem which is beyond the skill of the individual physiotherapist then the patient must be referred on to another more suitably qualified practitioner (2.2). Physiotherapists are also obliged to continue to develop their skills and expertise through ongoing formal education as well as through experience. This is important to maintain, enhance and broaden professional competence and to maintain good levels of skill and is the duty of all clinicians. In New Zealand this is done through the monitoring role of the Physiotherapy College. The maintenance of competency to practice is important in all areas of health care, but it can be argued that it is particularly important in physiotherapy, where over the past twenty years there have been many changes in the role and status of the practitioner. Individual physiotherapists are moving into new areas of practice and while they should be encouraged to be innovative and to try new approaches to treatment they must be careful that this is not taken so far that they find themselves practising some other health care profession under the guise of physiotherapy. If physiotherapists do move outside their area of expertise, perhaps by advising patients about drug therapies or by using a treatment modality in which they have received no training then they contravene this rule - even if no harm results for the patient. Physiotherapists are also encouraged to participate in peer review in order to maintain adequate standards of care (2.3).

Right 4(2), in giving consumers the right to have services provided that comply with legal, professional, ethical and other relevant standards provides a means by which
standards set by other bodies can be enforced. In physiotherapy practice this will refer to both the Code of Ethics and also to the Code of Ethical Principles referred to in the Rules of the Society. In a recent case the Commissioner found that a physiotherapist who failed to perform a neurological examination on a patient was in breach of Right 4(2) (Report on opinion- Case97HDC4720) because the performance of a neurological examination is regarded by the profession as a necessary practice.

Right 4(3) states that consumers have the right to have services provided in a manner consistent with his or her needs. Some have questioned whether this confers a right of access to services consistent with needs. However, this is unlikely to be upheld. The Code refers to the “manner” of provision and not the fact of provision. As was stated earlier, the Code must be read in conjunction with the Act and the Act makes it clear that the Code applies to the quality of services that are actually provided (s20(1)(f)). This right, in providing that services provision is consistent with need, does not state whose need is to be considered. In the acute care setting this is not usually an issue, as the goal of treatment is to cure and the patient and the health care professionals are generally in agreement with this goal. This is not always the case in rehabilitation medicine where patients and providers may have different values and different goals. Physiotherapists, working in rehabilitation, may encounter problems with assessing needs. In rehabilitation the goals are often broader than in the acute setting and dysfunction is chronic and irreversible at the physiological level. The critical goal is to mitigate the limitations that chronic illness and disability brings and to control the damage as far as possible. Health care professionals have to assume the role of educators and patients must be active in their own treatment. As there is no cure, the disability needs to be integrated constructively into the patient’s life and the aim of treatment becomes to restore function where possible and for the patient to adapt to it where restoration is not possible. Acceptance, by the patient, and a rediscovery of “self”, are also important goals.

There is also potential for disagreement about defining goals because providers and patients may have different priorities. Individual patients will have their own particular priorities. For example, the problems associated with a spinal cord lesion and the
prospect of life in a wheelchair will vary from individual to individual depending on factors such as age, existing support networks, previous employment, coexisting health problems and financial constraints. Disagreement about goals does not only occur between patient and provider but also between patients and their families, patients and their employers and third party payers and between the members of the rehabilitation team themselves.

It is also necessary to ask how we define success in rehabilitation. The physiotherapist, for example, is an expert in knowing how to achieve a given physical goal. They know how to optimise physical function and may see their success in terms of the mobility that a patient achieves. However, although they may know how to get to a given goal they cannot decide for the patient what the goal should be. While the physiotherapist may link success to a return to work or the use of orthotics instead of a wheelchair this may not be the patient’s goal. As Sim (1998) points out, “the optimum methods of rehabilitation can be objectively identified by the practitioner, but determining the appropriate goals of rehabilitation is ultimately the prerogative of the individual concerned, on the basis of his or her own subjective values and priorities” (p.6).

The requirement that providers strive to “optimise the quality of life” of consumers, as referred to in Right 4(4) is defined in Clause 4 as taking a “holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances”. In other words, providers will be expected to take into account not only clinical aspects of patient care but also the consumer’s social, personal and even spiritual needs. This has particular relevance for physiotherapists working in the rehabilitation area where it can be argued that rehabilitation is a matter of restoration of the spirit and the mind as well as of the body. In fact, Banja (1990) defined rehabilitation as:

A holistic and integrated program of medical, physical, psychosocial and vocational interventions that empower a disabled person to achieve a personally fulfilling, socially meaningful and functionally effective interaction with the world. (p.615)
While the Commissioner may find a provider in breach of the Code if a consumer suffers any harm, physical or otherwise, as a result of the provider’s actions, Right 4(4) goes further than that. Actual harm is not necessary for such a finding as the right provides that services must be provided in such a way as to minimise potential harm. This means that physiotherapists, like all other providers, must have in place safety management systems by which risks to consumers are identified and managed.

Right 4(5) gives consumers the right to cooperation among providers to ensure quality and continuity of services. The NZSP Code also highlights this right by advising physiotherapists that they should make provision for continuity of care if they are planning to be absent from practice (2.7); to keep accurate and up-to-date clinical records (2.5); and to keep the referring health care professional informed of the patient’s progress. However, maintaining cooperation among providers can be difficult for the newly autonomous physiotherapist. This is because full responsibility for clinical practice, once achieved, is jealously protected. An example of this guarding of practice rights is seen in the Rules of the British Chartered Society of Physiotherapy. It states that if a practice manager chooses to limit services by operating a medical referral system only, they must "openly acknowledge that this referral system is not a requirement of professional physiotherapy practice but is employed as a management strategy" (p.20). The responsibilities imposed on practitioners by the Code of Health and Disability Services Consumer’s Rights, along with the opportunity to contract for services, is seen by many physiotherapists as an opportunity for the profession to finally escape the medical dominance which has been a feature of its history, and to further pursue autonomous practice. Nevertheless, physiotherapists must remember that there is a link between accountability and autonomy; by making physiotherapists accountable, the Code also bestows on them increased autonomy. The Code will also force physiotherapists to assimilate ethical theory into their decision making because without it the advancement of the profession will be jeopardised. The aim of the physiotherapy profession, as stated by the Physiotherapy Board, is to emerge in the new health regime in New Zealand as independent, autonomous practitioners who are respected as musculoskeletal specialists (Katavich 1996).
However, if after examining a patient, the physiotherapist considers that the patient has been referred for treatment that is dangerous, unnecessary, inappropriate or of dubious benefit then there is a duty to refer the patient back to the referring source with a letter of explanation. In order to comply with the requirement to provide treatment that is consistent with the patient’s needs (Right 4(3)) and which minimises harm to the patient (Right 4(4)) it is unlikely that the patient should ever be given a treatment which is ineffective or which is just a placebo, although it is possible that this may occasionally be justified.

The issue of cooperation among providers is also an important issue in rehabilitation. In this setting treatment is carried out by a team, not just of doctors, but often comprising physicians, surgical consultants, physiotherapists, occupational therapists, speech language therapists, psychologists, social workers, vocational guidance councillors, diversional therapists, nurses and, potentially, students in each of these specialties. There may also be a case manager and external providers. This is unparalleled in any other area of medicine and so calls for extra care in ensuring that there is cooperation between providers to optimise patient care.

RIGHT 5: The right to effective communication

The Act states that the Code must contain provisions relating to the duties of health care and disability services providers “as they relate to the measures (including the provision of interpreters) necessary to enable health consumers and disability services consumers to communicate effectively with providers” (s.20 (1)(d)).

In the commentary which accompanies the Draft Code the Commissioner stated that many of the poor or negative outcomes in health care could be traced back to poor communication between the consumer and the provider (p.26). This was also highlighted in the Cartwright Report in which the judge commented that there needed to be greatly improved communication with all patients. She advised the use of skilled interpreters where necessary and the development of information sheets in visual as
well as written form (p.215). Many of the submissions which the Commissioner received when preparing the Code were concerned with poor communication. Without effective communication the partnership between the health care provider and the consumer quickly breaks down and the risk of poor service is increased. The requirement that a skilled interpreter be provided “where necessary and reasonably practical” has occasioned a great deal of comment. It is unclear whether, if a complaint about this is dealt with by the Complaints Review Tribunal, the onus will be on the provider to show that its actions, in providing, or in failing to provide an interpreter, were reasonable (Clause 3(2)), or, whether it will be for the plaintiff to show that the provision of an interpreter was “necessary and reasonably practical” (Right 5 (1)). Nevertheless, it would probably be thought unreasonable that a physiotherapist working in a small rural practice in Southland should be expected to access an interpreter for an occasional passing Japanese tourist. However, a physiotherapist working in an area servicing a large Samoan community might well be expected to comply with this rule. This right might also apply when the first language of the service provider is not English and the consumer finds the provider difficult to understand. The Commissioner takes this right so seriously that she stated in a recent seminar that if not having an interpreter means that the provider’s obligation to provide services with reasonable care and skill cannot be met, then, in her view, no service should be provided. (Unravelling the Code. Presentation to the Marie E. Burgess Seminar, “Getting it right – managing risk for health care professionals”, April 1998).

Right 5(2) states that the consumer has the right to "an environment that enables both consumer and provider to communicate openly, honestly and effectively". This is an area which physiotherapists need to address. They should, as far as possible, talk to patients when they are fully dressed and sitting rather than undressed and lying down which only emphasises the power differential between the patient and the health professional. The physiotherapist also needs to bear in mind the fact that hospitals and physiotherapy departments, while comfortable and familiar to the professional, can be intimidating places to many consumers and they may need reassurance and support. Language used must be accurate and easily understood by the patient. Physiotherapists also need to recognise that, when giving information to the patient, there is a
psychological dimension that may influence the patient's understanding of what is being said. The "how" of information disclosure can be even more important than the "what". The physiotherapist should keep in mind the advice offered by Higgs (1994): "There are ways of offering a truth, which can be more harmful, or less. There are ways of communicating which can empower or destroy" (p.505).

The importance of good communication is not officially recognised in the Rules of Professional Conduct of the British Chartered Society of Physiotherapy of 1996 or in the rules of the New Zealand Society of Physiotherapy. Neither Code makes mention of the need for clear and honest communication. Neither have any articles appeared on the subject in physiotherapy journals although it is referred to in passing in several. When it is considered it is often concerned with physiotherapists communicating with doctors and other health care professionals rather than with patients (Gartland, 1987; Hulme, Bach & Lewis, 1988; Ross, Roberts, & Olsen, 1980; Thompson, 1979). While good communication with doctors is important, in that it results in better patient care, it is also important that the physiotherapist can communicate easily with patients and relatives.

RIGHT 6: The right to be fully informed

Right 6 of the Code is headed "Right to be fully informed" although Skegg (1997) comments that it is far from certain that Right 6 does in fact confer a right to be fully informed. It is important that Right 6 comes before Right 7 because consent is not valid unless there is a sufficient understanding of what is being consented to. This further emphasises the pivotal nature of Right 5, in that unless communication is effective the patient cannot be fully informed. This separation of the right to information from the right to give consent emphasises the point that there is a right to information even if there is no treatment available, and therefore no question of the need for consent (Right 6(1) (a)). The Code upholds that part of the standard of the Australian Rogers v Whitaker ((1992) 109 ALR 625) decision stating that the information given must be that required by a "reasonable consumer, in that consumers' circumstances". Indeed the
Commissioner stated in the draft Code that she considered it appropriate "to adopt the standard followed in North America and Australia" (p.33). The Code also goes further than the Australian case in that it extends the duty of provision to all health care and disability services providers and the rights to all consumers of both health and disability services. However, in some respects the Code is more restrictive than Rogers v Whitaker, which also required disclosure of information about risks which the practitioner “is, or should reasonably be aware that the particular patient (emphasis mine), if warned of the risk, would be likely to attach significance to it”. Although the consensus of medical opinion, with regard to information disclosure, is relevant, it is no longer the final determining factor.

The Commissioner has recently considered a case involving a physiotherapist where she found the physiotherapist in breach of Right 6(1)(a) and Right 6(1)(b) as well as Right 7(1) (Report on opinion – Case 97HDC4720). The consumer claimed that the physiotherapist manipulated her neck without her consent and without any explanation of the procedure. However the physiotherapist stated that the patient’s neck was not manipulated but simply examined and mobilised. It is clear from reading the Commissioner’s report that not only is there confusion over what took place during the consultation but also confusion about what a physiotherapist may mean by the word manipulation and what a consumer understands by that same terminology. The Commissioner found that the provider did not provide the consumer with the information that she had a right to receive to enable her to make an informed choice about treatment. The Commissioner has sent a copy of her findings to the Physiotherapy Board and also referred the case to the Director of Proceedings for the purpose of deciding whether any action should be taken in accordance with section 45(f) of the Health and Disability Commissioner Act 1994.

Right 6 (3)(b) states that providers are required to give their recommendation to the consumer when asked. As mentioned earlier, this can reintroduce bias; on the other hand, it is surely sensible that the consumer, having consulted an expert, is entitled to the opinion of that expert. There is a further challenge here for the professional in this new era of accountability where the patient is seen as a "partner". Whilst in the past
professionals were expected to play the role of the expert there is now the expectation that they may, from time to time, reveal their uncertainties. Professionals used to keep their expertise private and mysterious but they are now expected to reflect on their knowledge publicly and make themselves confrontable by their clients (Schon, 1983). If consumers are to be empowered to make informed choices they need to be advised of all treatment options, including ones which are not publicly funded. For example, the physiotherapist working in a private practice who is treating a patient who has used up his full entitlement to ACC funded treatment must inform the patient of all his options. He can continue to receive treatment from the private practitioner at full cost; ACC can be approached to see if they will fund further treatment; or he may be able to receive free treatment from the hospital physiotherapy service. The physiotherapist, in offering the patient these options, must be careful to do so from a consumer choice perspective and not involve personal political views or press the patient to choose the option which would be of financial benefit to the physiotherapist. The Commissioner, in her report for the year ended 30 June 1998, sees this Right (6(1)(b)), as an important protection for consumers in a more commercialised health care system (Report of the Health and Disability Commissioner. E17. P.7).

RIGHT 7: The right to make an informed choice and give informed consent

The ethical and legal issues involved in giving an informed consent were discussed in Chapter 2.1 and so will not be considered again here.

It should be noted here that the word "consumer", when used in rights 5, 6, 7(1), 7(7)-7(10) and 10 also applies to a person who is entitled to give consent on behalf of that consumer. Those who are sometimes entitled to give consent for others are set out in the Guardianship Act 1968 (s 25), the Children and Young Persons and Their Families Act 1989 (ss 49, 53, 114, 149, 181) and the Protection of Personal and Property Rights Act 1988 (ss 6,7,12,18).
It is also interesting to note the use of the word "choice" as well as consent. Although the word "choice" is not used in the Act, the underlying philosophy is that each consumer is an individual and therefore must have services provided in such a way as to demonstrate respect for that individuality. This use of language emphasises the point that the consumer is taking an active role in decision making by making an active choice rather than by mere passive acquiescence.

Right 7(1) states the foundational principle that services can only be provided where a consumer has made an informed choice and has given informed consent, except where any enactment, the common law or the Code itself provides otherwise. Consumers also have the right to withdraw their consent at any stage (Right 7(7)). Right 7(2) assumes that patients are competent and Right 7(3) states that even patients who have diminished competence still retain the right to make informed choices "appropriate to his or her level of competence". The Code does not contain any provision about who is entitled to consent on behalf of others.

Right 7(8) gives the consumer the right to express a preference as to who will provide the services and to have that preference met where practicable. This right to choose is not extended to the service provider. Physiotherapy Codes of Practice say that the physiotherapist cannot refuse to treat a patient for reasons of sex, race, religion, sexual orientation or condition, because "physiotherapists have no right to be selective about patients" (CSP Code, p. 13).

RIGHT 10: The right to complain

In accordance with one of the stated purposes of the Act, which is to assist lowest level resolution of patient complaints, Right 10 sets out the right of consumers to make a complaint about a provider. The complaint may be made directly to the provider; to any person who may be authorised to receive complaints about the provider; to an independent patient advocate or directly to the Commissioner. The Commissioner may refer a complaint to an advocate so that the complaint can be resolved by agreement.
between the parties concerned; investigate the complaint herself; or decide to take no further action (Health and Disability Act, s 36 (1)(a)-(c)). Investigations by the Commissioner into complaints are designed to be inquisitorial and not adversarial. Any complaints received directly by a health registration board, such as the Physiotherapy Board, must be sent to the Commissioner. The boards may not take any action until the Commissioner has determined what action, if any is to be taken under the Act. If the Commissioner thinks that the Code has been breached the complaint may be referred to a professional body such as the New Zealand Physiotherapy Board (s.38 (k)) or the Commissioner may refer them to the Director of Proceedings (s.45(f)) who can, in turn, choose institute proceedings before the Complaints Review Tribunal (s.50). It is at this stage that there can be limited, statutory remedies. The Director of Proceedings can make a declaration, an order, or award damages. Despite fears to the contrary his process does not seem to have led to a “culture of complaint” and very few cases have been referred to the Complaints Review Tribunal.
Chapter 5: The professional/patient relationship and the Code.

Nothing in medical ethics has changed so dramatically in the last quarter century as the standards of ethical conduct governing the relationship between doctors and patients. (Pellegrino, 1994, p.354).

Physiotherapists would not dispute this statement, but their own relationship with patients has not been discussed in the physiotherapy literature. There have been several articles that have considered the relationship between the physiotherapist and the doctor (Bruckner, 1987; Hulme, Bach & Lewis, 1988; Ross, Roberts & Olson, 1980; Thompson, 1979) but none have concerned the relationship with the patient. In the new health care environment in New Zealand, it is important that this issue is discussed.

The traditional model for the relationship between the health care professional and the patient is the paternalistic model. This model casts the provider in the role of decision-maker, a role they adopt because of their superior knowledge, training and expertise. The provider is the active party and the patient is the passive recipient of care. Although many health care providers would consider this model outdated many still, perhaps unconsciously, operate according to its principles. In a study cited by Wegener (1996) over two thirds of the requests made to clinical psychologists for assessment of the competency of clients were initiated by the client's disagreement over treatment decisions. Differences of opinion between patients and health care professionals should not, in and of themselves, provide sufficient grounds for challenging patient competency.

However, in recent years, the emphasis on the relationship between the patient and the health care professional has shifted almost completely from the professional to the patient. The traditional image of the health care professional as a benign and respected authority on moral and technical matters has been replaced by the health care professional as a protector, facilitator and advocate of patient self-determination. In the past, unless certain boundaries of competence or behaviour were breached, the relationship between the patient and the health care professional were considered to be
a private matter between the two individuals concerned. As such it had little to do with either ethics or law and was principally governed by etiquette. The same was true in physiotherapy and the early ethical rules of the New Zealand Society of Physiotherapists hardly mention the patient at all. Right up until the early 1990's physiotherapy Codes summed up the relationship between the physiotherapist and the patient by requiring the physiotherapist to always act in the patient's best interest. These statements have an obvious meaning but they can be interpreted in several different ways. They beg the question of who should decide what is in the best interest of the patient and whether or not the physiotherapist is ethically bound to accept the patient's judgement as to their best interest. It is not uncommon for physiotherapists to treat patients with conditions such as back pain who seem to consider that it is in their best interest to perpetuate their condition in order to remain in receipt of payment for their incapacity.

Unfortunately, as was seen in Chapter 3, there have been several occasions in the recent past when patients felt that they had been treated badly, not necessarily in terms of the actual treatment received, but because of the way in which they were treated. Collins (1992) states that communication problems are a key factor in patient's complaints to professional disciplinary bodies. In New Zealand, when the Cartwright Report highlighted poor communication and poor therapeutic relationships, the answer was seen to be to legislate against it in the form of the Code of Health and Disability Services Consumer's Rights. However, as will be seen, the Code introduces complex dilemmas about the role of the law in regulating behaviour within the therapeutic relationship.

Autonomy

In the past thirty or so years autonomy has emerged as the dominant notion in biomedical ethics (Agich, 1990; Campbell, 1994; Jennings, Callahan, & Caplan, 1988). It has become a “given” in health care, through the influence of Court rulings, Government regulations and institutional policies. This is a sharp departure from the
benign paternalism that characterised the Hippocratic tradition. The "autonomy paradigm" has led to illness being seen as an alien threat to the self, the total acceptance of the contractual model of health care and an individualistic conception of the person (Jennings, Callahan & Caplan, 1988). The Code of Health and Disability Services Consumer's Rights, with its rights and duties wording, is firmly based on the autonomy of the patient and therein lies much of its appeal. It ensures that patients can choose between treatment options (Right 7) and so maintain control over some of the most important, intimate and personal decisions of their lives. They are also protected against the submergence of their moral and cultural values and beliefs (Rights 1, 3 and 4) and it acts as a deterrent to the abuse of power by the provider (Right 2).

However, there are an increasing number of writers who suggest that there is an overemphasis in current bioethics on the right to autonomy (for example, Campbell, 1994). They claim that it is a myth that we are always autonomous and to assume that we are is just to avoid the difficult decisions that confront health care providers. Campbell asserts that the elevation of autonomy as a central principle in health care is unfortunate as it has led to illness being seen as a threat to self-determination. He claims that dependency, rather than autonomy, is a common experience. He defines dependency as "being in relationship to others in a manner which makes them necessary for the fulfilment of some or all of our needs" (p.185). This definition seems to describe quite well the relationship that exists between the health care professional and the patient. Agich (1990) agrees with Campbell and describes dependency as a "non accidental feature of the human condition" (p.12)

Some writers have called for a new "bioethics of chronic illness" to replace the dominance of the principle of autonomy which, they claim, is inadequate to respond to the need of the chronically ill and disabled (for example, Carter, 1993). This "new" bioethics should emphasise the self, not simply as an autonomously self-sufficient individual, but as a person who exists within a community and within a set of relationships to others. As discussed earlier, some cultural groups, including Maori,
already see themselves in this way. Therefore it could be that this new model would be more appropriate for them too.

It was pointed out earlier that until recent years the early Codes in physiotherapy were based on the beneficent idea that physiotherapists should act in the patient's best interest. The autonomy movement of the last twenty or so years has often resulted in beneficence being equated with paternalism and being placed in opposition to autonomy. However beneficence and paternalism are not synonymous. While paternalism is in polar opposition to autonomy it is also in opposition to beneficence for disregarding the patient's own perception of their welfare can only in rare circumstances (when the patient is suffering from a psychiatric illness for example) be in their best interest.

The contractual model

The pre-eminence of the principle of respect for autonomy leads to a different model for the health care relationship – the contractual model. This is a more egalitarian model than the paternalistic model. In this model health care is viewed as a commodity or service like any other that the consumer can purchase on the consumer's terms. The health care professional's duty is to give reliable information, to deliver a competent service, to protect the patient's autonomy and to refrain from imposing his or her own views. It is based on the idea of increased patient participation and sees the patient as an active participant in choosing, planning and implementing treatment. This model places a high value on autonomy, truth telling, informed consent, confidentiality and privacy. This model is in line with other consumer laws in which the law seeks to increase the consumer's range of choice and elevate his or her position to one of equal bargaining power with the provider of goods or services.

It can be argued that the contractual model is legalistic in spirit and is based more on distrust than trust. The ethic it engenders is one of minimal personal commitment. Although it appears to protect the patient's right to self-determination it neglects the
fact that, despite all efforts to the contrary, the health care professional and the patient are not "Lockean free agents" equal in bargaining power. It ignores the power imbalance that exists in the relationship due to the fact that one party is sick, frightened, distressed, anxious and in pain and is dependent on the other for information and help. It might be argued that very few patients who consult a physiotherapist, especially in the out patient or private practice setting, are distressed or frightened in this way and so perhaps the contract or consumer model is more appropriate there. However, even if this type of power imbalance does not exist there will still be other inequalities. The physiotherapist has the monopoly of knowledge and a certain institutional position that gives prestige. It is also the physiotherapist, not the patient, who decides on the length of time allocated to the treatment and who determines when the treatment should cease. All of these factors perpetuate the imbalance between the patient and the physiotherapist.

The Code and the professional/patient relationship

The Code is based on a contractual model and can be described as a mixture of both 'rules' and 'principles'. Right 7, for example, sets out specific rules that must be followed in obtaining patient consent to treatment whereas Right 1 is an example of a principle - the principle that the patient should be treated with respect. This causes problems for the health care provider in that the Code is turning the principles of good professional communication into legal requirements. It is unclear how the law can impose a duty to act on such principles.

The use of the language of rights in the Code is also damaging to the professional/patient relationship. One property of rights is that they acknowledge an equal relationship between the two parties, the right holder and the right granter. The usual situation in which a person asserts a right is when the person against whom it is asserted threatens, neglects or otherwise appears unwilling to accede to the right holder's requests. The assertion of a right is, in this sense, reactive. Therefore the concept of rights is most commonly used in an adversarial context, surely the last thing
that is needed if the relationship between the consumer and the provider is to be improved. If a request is based on a right it may well destroy the relationship altogether because it implies an absence of trust. Another problem with the rights model is that it an ethic of rights tends to be static and not subject to change and development. Rights are pre-existent and predetermined before the decision process begins and so leave little room for the kind of mutual accommodation that may be necessary to change the situation for the benefit of the patient.

Another feature of the Code is that it breaks new legal ground in that 'ethics' has been written into legislation with Right 4(2) which states that "every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards". In the past ethics has been concerned with 'moral dilemmas' and decision making and had little to do with the concerns of patients. May (1991) points out that:

> Modern philosophers and theologians have concentrated chiefly on moral dilemmas. They like to identify quandaries that the decision-maker faces and then search for moral rules and principles that will help to solve or resolve these moral binds...but this approach does not offer much insight into the ordeals confronting patients that do not wholly admit of solution. Such problems must be faced rather than solved. (p.3)

In the Code the health care professional is also charged with respecting the patient (Right 1(3)), respecting the dignity (Right 1(1)) and independence (Right 5) and optimising the quality of life (Right 4(4)) of the patient. In short, he or she is required to demonstrate personal virtues in their clinical practice. Can, or should, such ethical ideals, be made compulsory? Honore (1993) argues that to make virtues compulsory means that they cease to be virtues. However, this is exactly what is being done in the Code where moral and ethical ideals become legal obligations.
While the Code appears to subscribe to a wider view of the health care professional’s role, its location within law and its ‘rights and duties’ model are based on the primacy of the patient’s right to autonomy.

The professional/patient relationship in physiotherapy

While the contractual model provides benefits for patients in attempting to remove some of the inequalities between consumers and providers, it fails to consider the problems encountered by many physiotherapists, and other health care professionals, who work with the disabled or the chronically sick.

The widely accepted principles of biomedical ethics have been developed mainly within the emergency/acute care medical traditions. This might be because rehabilitation is less dramatic than critical care medicine where life and death decisions are relatively common place. Critical care medicine tends to be crisis centred, dealing with acute conditions of sudden onset that are limited both in time and scope. Treatment interventions are aimed at curing or reversing a specific physiological condition and the primary goal is to preserve life. Patients play a relatively passive role during the treatment process. Relationships between practitioners and patients are usually discrete, finite and episodic and patients are assumed to be competent and autonomous. This has helped to promote individual autonomy and protection of personal rights. Competent patients must be given the right to control what happens to their bodies in any medical encounter, even if death or disability is the result. As discussed in an earlier chapter, the Courts have also upheld this position.

Recent literature has suggested that these principles cannot be simply transferred to the rehabilitation setting where the problems encountered by the patient, the health care professional and the family are different (Caplan et al, 1997; Jennings et al, 1988; Schofield, 1993). In rehabilitation medicine there is often no cure, there is more medical uncertainty about the disease process and more variability of symptoms. Interactions span many months and even years can be said to be very invasive.
Treatment does not make extensive use of life saving technologies, and patient compliance is vital as treatment is done with, and not to, the patient. Although decisions about the right to refuse treatment do arise in rehabilitation, often the primary concern of the patient is how to learn to live with technology rather than how to die without it (Schofield, 1993). Further, treatment is not usually be carried out in a hospital but is more likely to be in the patient’s home or some other institutional setting and the involvement of families, and even employers, is essential.

Because the ethical issues in rehabilitation medicine are so different from those encountered in acute medicine, a different model has been suggested for the patient/practitioner relationship. Several writers have suggested the educational model and others have suggested the covenant model.

**The Covenant model**

Some writers have said that the covenant model would be a preferable model for the patient/professional relationship (for example, Campbell, 1994; Gillett, 1989; May, 1983). This model accepts the asymmetry of the relationship between the two parties and acknowledges that the health care professional has greater expertise and experience and also acknowledges the inescapable dependence inherent in the relationship. However, it does not undermine the need for sharing of information or the professional’s duty to ascertain, and then respect, the wishes of the patient. The two parties enter into a relationship where both are respected for who they are and the welfare of the patient is safeguarded in a climate of trust.

**The Educational model**

Health care professionals working with patients who have a chronic illness or with patients undergoing rehabilitation need a model which is sensitive to the patient’s evolving capacities and adaptations over time and to the fact that this is not a one on one relationship. In the educational model there is more leeway allowed in the early
stages. It allows for an initial paternalistic role. Infringement of autonomy is allowed in the early stages where this can be justified as enhancing future autonomy. However informed consent must always be sought when an invasive or potentially harmful treatment is contemplated. This intervention is based on trust, which is an essential component of the patient/therapist relationship. Patients need motivation and encouragement, as the future may look bleak. They have to accept their new health status and those facets of it which are unable to be changed. In the early days of their hospitalisation they may not be interested in rehabilitation, as the "reconstructed identity towards which healing must point does not loom before the patient as an unambiguously desirable goal" (May, 1991, p.8). May further reminds us that patients have to move from "an old identity beyond recovery to new selves on the other side of the ashes. Their problem is radical reconstruction from the ground up and not merely patchwork that attempts to obscure or minimise the loss" (p. 143).

For these reasons the educational and covenant models may provide a better model for the patient/professional relationship than the contractual model in the Code, especially for physiotherapists and other health care professionals working in the area of rehabilitation.
Chapter 6: Towards the future

The future of the Code

The Code clearly achieves its objective, as prescribed by the Health and Disability Commissioner Act, in setting out the rights of consumers and the corresponding duties of providers. While the main focus of the Code is on the interaction between the two parties, the duties of only one party, the provider, are stated. As discussed there are limitations in this approach. While it is not difficult, given the historical examples, to justify the need for such a Code it is debatable whether legislation is the most appropriate way to achieve an improvement in the relationship between consumers and health care professionals. As Pellegrino and Thomasma (1988) state “the more we yearn for ethical sensitivity, the less we lean on rights, duties, rules, and principles and more on the character traits of the moral agent” (p.122). In the physiotherapy literature Purtilo (1986) has a similar view and she warns that “rigid adherence to duties and rights can lead to professional conduct that lacks heart, or worse, is ineffectual” (p.582). Townshend, Sellman and Haines (1998) claim that, in the Code, providers have little guidance as to what they can expect from their patients “other than that if anything goes wrong it’s the health care provider that is likely to be found wanting” (p.390).

In accordance with the provisions of the Act (s.21) the Act and the Code will be reviewed in 1999. If the public, and also health care providers are to continue to support it developments in consumer rights and provider duties need to move hand in hand with developments in the awareness of consumer obligations and provider rights. This will enhance the model of health as a partnership between providers and consumers. In her 1998 report the Commissioner comments that there has been a shift in New Zealand in the past few years from health as a vocation to health as a business. This shift has resulted in an increased emphasis on quality service and risk management and she suggests that the Code can be “sold” to providers as a quality improvement tool. It could also act as a protection for patients against some of the harsher aspects of a business centred health environment in that it requires consumers to be given
information about all the options available to them (Right 6(b)) and not just those purchased by a particular fund holder (Report of the Health and Disability Commissioner, E.17, p.7).

Nevertheless, whatever its shortcomings, the Code does ensure some basic minimum standards. Without it we might, like the children of Israel when they had no King, revert to a situation where each health care professional “did what was pleasing in his own eyes” (Judges 17v6 King James Version).

The future of physiotherapy

The Book of Rules of the New Zealand Society of Physiotherapy states that physiotherapists must accept responsibility to uphold the integrity of the profession (n.60) and to practise in accordance with acceptable professional standards (n. 59). In order to do this and to make a meaningful contribution to the care of patients in the new millennium, they must do all they can to create a broad base of understanding of the ethical issues facing the profession. There is a need for physiotherapy schools to develop their own programmes of ethics teaching. It is important that these are relevant to the practice of physiotherapy because “anyone forced to rely on the judgement of another in moral matters is in danger of violating not only professional training, but also personal convictions” (Thomasma & Pisaneschi, 1977, p.115).

The NZSP Code also states that physiotherapists must comply with “all legislation that governs and impacts upon the practice of physiotherapy” (n.58). Therefore physiotherapy schools also need to incorporate education about the Health Information Privacy Code and the Code of Health and Disability Services Consumer’s Rights into their curricula. As has been demonstrated, these pieces of legislation have an impact on the practice of physiotherapy and without specific training in relevant legal matters and “everyday ethics” the physiotherapist may become both professionally and personally enfeebled. Purtilo (1996) suggests that if physiotherapists strive to create a broader base of understanding about the ethical issues which face the profession they are more likely


British Medical Journal, 14 July 1894, p.88


HM (62) 18, Physiotherapy in hospitals. Para II (iii)


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