"ETHICAL PRINCIPLES AND PATIENT REFERRAL"[1]

by

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I am not a Philosopher by profession. I cannot claim to have a profound knowledge of the subject, "Ethics". But as a physiotherapist, I can claim to be concerned about the moral obligations of my profession to the public it serves: and it is from this basis that I feel qualified to speak.

Not all of you may agree with what I am going to say. This is understandable, because each individual's assumptions of what is "good" or "bad" for example, depends on the socio-cultural forces to which she has been exposed. What really does matter is that in this period of rapid social change, our profession must reconsider its ethical position on a number of issues, so that it can make the best possible contribution to humanity.

The major issue today, in my view, is that of patient referral, because it is mainly through the process of referral that the physiotherapist is able to make full use of her knowledge and skills.

Item 1 of the present Ethical Principles of the Australian Physiotherapy Association states that: "it is unethical for a member to act in a professional capacity, except on referral by a registered medical or dental practitioner". Is this principle ethically justifiable in Australia, in 1975?

Stated another way, is it in the public's best interest that the decision, whether or not an individual may have the professional services of a physiotherapist, should be left solely to medical or dental practitioners, or is it better that referral sources for physiotherapy be made as wide as possible?

I propose to argue that the latter is the choice that we as a profession must make; at the same time, recognizing and accepting the increased responsibilities resulting from such a decision.

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THE "DEPENDENT" SYSTEM

Why is the present "dependent" system of referral not in keeping with today's situation?

The physiotherapy profession has, over the past decades, been developing a body of knowledge primarily focussed on human movement and its abnormalities. Specialized techniques, not involving the use of drugs, have been developed and improved upon — mainly in the clinical setting. The necessity for more vigorous investigation into the scientific basis and the clinical implications of all these developments is recognized by the profession, and there are indications that physiotherapists are now willing, and able, to undertake such research responsibilities.

The implication of this growth of knowledge within physiotherapy is that as a group, the profession can rightly claim a greater collective expertise than previously, particularly where this is applied to whether or not physiotherapy can help a particular individual's movement problem.

In these circumstances, it seems illogical that only medical and dental practitioners are presumed by the physiotherapy profession to possess the expertise to decide whether physiotherapy will be useful or not, in every situation. If we claim expertise, we should use it fully for the public good. The decision whether physiotherapy can be used is a physiotherapy decision, not necessarily a medical or dental one. This is not to say that in many instances it is not useful for the physiotherapist to be provided with a differential diagnosis, of the kind a medical practitioner is educated to make, to help in her own decision making. But it is important for physiotherapists and others, to recognize that a medical problem may not be the major cause of a person's movement disability: thus the need for a medical or dental practitioner to be involved in every case attended by a physiotherapist in her professional capacity would seem unnecessary.

Furthermore, with the growth of knowledge, particularly in the health field, how can medical and dental practitioners during their formal education hope to become more than basically acquainted with what physiotherapy can offer? Is this an adequate basis on which to make the best decisions regarding their patients?

The present Ethical Principles of our Association would seem to indicate that it is, but I cannot see that it is in the best interests of the patient. 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.

A NEW SYSTEM

What sources of referral then, should be considered acceptable by the physiotherapy profession?

A major source of referral would remain the medical and dental professions, indicating a shared basic philosophy in relation to medicine. However, I argue that retaining this as the sole system of referral is not ethically justifiable today. Referrals from other sources must also be accepted.

Referrals made by physiotherapists to colleagues must be considered acceptable, now that specialization is growing within the profession. A physiotherapy consultant's services will only be fully used when she is free to accept referrals directly from colleagues who are themselves free to refer to her. I realize that the present system allows for consultation of one physiotherapist with another; but this is only with the consent of the referring medical practitioner — a courtesy, but a barrier too.

Physiotherapists should be able to accept referrals directly from members of professional groups other than those already mentioned: occupational and speech therapists, nurses, psychologists, teachers, social workers, engineers. The interdependence of all professionals concerned with health care must be recognized increasingly if the unique areas of knowledge and the skills possessed by the various professions can be blended satisfactorily for the patient's good. By denying referral rights to these fellow professionals, I would suggest that we, as a profession, are failing to recognise legitimate areas of expertise which may give greater insight into some of the non-medical causes of a person's movement problem, which in some instances may be primary. Such a failure, by our profession, denies the public the full benefits of the rapid advances in expert knowledge.

Most importantly, members of the public should be able to approach the physiotherapist directly for specialized help. By making it possible for persons to consult a physiotherapist without first having to see a medical practitioner in every case, we make it easier to protect the public from "fringe practitioners", whose philosophies of treatment are not acceptable to either the physiotherapy or medical professions.

Although some of their treatment methods may be similar, the physiotherapy profession stands for the safest use of treatment methods medical science can guarantee; it cannot condone "quackery". Therefore, physiotherapy is under a moral obligation to act, in this case by accepting the principle of lay-referral, even though it will entail a greater legal and ethical responsibility.

PROTECTING THE PUBLIC INTEREST

How can the physiotherapy profession ensure that the public interest is protected, if methods of referral are widened as suggested?

Traditionally, physiotherapy is based on a scientific philosophy shared with medicine. This philosophy will continue to influence much of the practice of physiotherapists, particularly when recognizing the limitations of physiotherapy in dealing with certain medical problems.

However, this is not the sole guarantee that the physiotherapy profession can or should offer. As Goode (1957) has noted, "client choices are a form of social control. They determine the survival of a profession or a speciality". By widening its referral sources, the physiotherapy profession is placing its worth "on the line", so to speak. I would argue that for our society, this can only bring good in the long term: for if physio-

therapy cannot live up to its claims, it will disappear; but if it has as real a contribution to make, as it now claims, it will survive and grow, and society will benefit.

A mature acceptance of the greater legal and ethical responsibilities to be undertaken as a result of widening referral sources, is perhaps the best guarantee the physiotherapy profession can offer the public. Individual physiotherapists will need to accept that they will become increasingly accountable to the public they serve, in both a legal and a moral sense. The professional body will need to accept greater responsibility for maintaining the highest standards of competence and integrity of its members. Registration laws will need to be expanded and strengthened.

If the physiotherapy profession accepts that it is no longer ethically justifiable to accept only medical or dental referrals, it must follow that the profession is morally obliged to change its ethical stance to accommodate the new thinking. I should like to suggest some guidelines for future action, focussing on the formulation of a new Ethical Statement or Professional Code.

By changing the present referral structure, the profession will be changing its relationship to the society it serves. To cater for this, any new Ethical Statement by the profession will need to be more detailed than at present because it will need to indicate the rules of professional conduct to be observed in these relationships, as well as clearly indicating the general ethical principles underlying the rules.

A new code then, should be made up of twc separate but related parts: Part I, being a statement of the general ethical principles accepted by the profession, and Part II, being a set of rules of professional conduct arising from and related to the general principles of Part I.

For example, in Part I, expression would be given to the importance placed by the physiotherapy profession on such principles as:

1. recognition of the responsibilities and limitations of the profession;
2. maintenance of a high level of professional competence, so that the public is better served;
3. high professional and personal integrity of members;
4. service to humanity unrestricted by considerations of nationality, race, creed, colour, politics and social status.

General acceptance of these ethical principles would not be difficult to obtain. However, relating rules of professional conduct to such broad principles could present difficulties. But the task is not impossible.

I have argued that growth in our profession's knowledge base is one of the prime reasons why we need to re-assess the profession's position on the issue of patient referral. However, with this same growth of knowledge should come a recognition and acceptance of the profession's limitations. To reflect this particular situation, a general ethical principle such as, "Physiotherapists recognize not only the responsibilities, but also the limitations of their professional functions", could reasonably be placed in Part I of the system I have proposed. This particular principle could then be related to a rule of professional conduct, which may be framed in words similar to those used in the Australian Psychological Society's *Code of Professional Conduct and Advice to Members, 1970,* namely: "When there is evidence of a problem or a condition with which the member is not competent to deal, it is essential that this be made clear to the client, and that he be referred to the appropriate specialist."

If a new referral system is accepted, the profession will face a period of transition in which it will be morally responsible to provide adequate guidelines to members to prevent misunderstandings which could ultimately harm the patient. Part II of the proposed ethical system would need to contain a detailed set of practical rules covering such areas as relationships with patients, physiotherapy colleagues, other professions, employing organizations and the general public.

NEW RELATIONSHIPS

What aspects of these relationships should be covered by these rules? By way of suggestion I shall indicate a few.

1. *Relationships with Patients.* As an extension of rules relating to placing the

patient's welfare first, guidelines relating to the pursuit of continuing education programmes could legitimately be covered here, if it be accepted that it is through such activities that professional competence is maintained and that by being competent, the physiotherapist can offer the best service to the person in need.

2. *Relationships with Physiotherapy Colleagues.* The growth in numbers of physiotherapy consultants will require that rules governing the etiquette of the consultation process be clearly outlined.

3. *Relationships with Other Professions.* Obviously, clear guidelines will be necessary in the early stages of any new referral system, particularly in defining relationships with the medical profession. Failure to do this could lead to misunderstandings which could be injurious to the patient.

4. *Relationships with Employing Organizations.* As more physiotherapists come to work in organizational settings, the profession will need to provide members with guidance as to how they can preserve their professional integrity within an increasingly bureaucratic system.

5. *Relationships with the General Public.* With the growing influence of mass-media in public affairs, a lead needs to be given as to what is responsible professional behaviour when dealing with the public through them.

As a final point to consider, one area where guidance will become increasingly necessary, if our claims to be a responsible profession are correct, will be in the area of clinical research. Rules relating to the conduct of clinical physiotherapy research, ensuring that patients' rights are protected, are urgently needed.

I have only briefly indicated some of the important areas that will need to be considered in making a new ethical statement. But whatever the final code contains, it will need to reflect the profession's moral obligation to society today and, as far as it can ascertain, in the future.

But such an ethical statement should never be considered to be the final word for all times. We must keep up to date if we are to fulfil our moral obligations to the public we, as physiotherapists, serve.

REFERENCE

GOODE, W. J. (1957), "Community within a community: the Professions". *Amer. Soc. Rev.*, 22; 194-200.