Informed Consent: Ethical theory, legal obligations and the physiotherapy clinical encounter

by

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Abstract

Obtaining a patient’s informed consent to treatment is an expected component of clinical interactions. The notion that a person as an autonomous being has a right to decide whether or not to consent to medical treatment from an informed basis has its origins in both law and ethical theory.

In this research I investigate the issue of informed consent from two overall perspectives. The first concerns its basis in ethical theories of autonomy and its interpretation by the law and by health professional guidelines. The second involves an empirical examination of its occurrence within the communicative interaction between a physiotherapist and their patient, and its interpretation by the physiotherapist. I use qualitative research methods involving analysis of individual audio-taped treatment encounters in private physiotherapy practice and interviews with the treating physiotherapist.

A central tenet of this study is that the translation of both legal and ethical criteria into the context of the clinical encounter requires a process of negotiation and communicative interaction between the patient and health professional. This research seeks to understand this process, and the factors that influence it in the specific context of physiotherapists and the private practice clinical encounter.

My examination of ethical theories of autonomy and their implementation in models of informed consent demonstrates that they provide a useful ethical framework for physiotherapy clinical practice. In particular, they highlight the importance of respecting both rights and capacities of patients, to contribute autonomously, in the clinical interaction.

I found that the most visible ethical framework underpinning therapists’ communication with their patients, including the way they obtained patients’ informed consent to treatment, was one of beneficence. Therapists valued and defined their role as the provider of treatment and the person responsible for solving patients’ problems. They valued patient trust on the basis that it enhanced their ability to effectively treat their patient and they valued patients who complied with and contributed to the therapeutic goals of the clinical encounter. Therapists’ communication with their patients was motivated by the overriding goal of producing a therapeutic benefit, rather than enhancing or promoting their autonomous contribution. Therapists defined and implemented the informed consent process as part of their routine clinical interactions. This meant that obtaining patients’ informed consent consisted of therapists giving patients information in the
form of explanations and clinical justification of their treatment. In so doing, therapists remodelled informed consent underpinned by autonomy to be informed consent grounded in beneficence.

Based on my analysis of both ethical theory and clinical practice, I make recommendations about the ways to increase the coherence between the ideals within ethical theories of autonomy and the goals and practices of the physiotherapy clinical encounter. The recommendations comprise ways to enrich physiotherapy clinical practice with ethical theory, to re-examine physiotherapy practice goals and to reframe and re-constitute current physiotherapy communication strategies.
Declaration

This is to certify that

i) the thesis comprises only my original work towards the PhD;

ii) due acknowledgement has been made in the text to all other material used;

iii) the thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.
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Glossary of Terms and Acronyms

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<tr>
<td>IFOMT</td>
<td>International Federation of Manipulative Therapists</td>
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<tr>
<td>MPAA</td>
<td>Manipulative Physiotherapists Association of Australia</td>
</tr>
<tr>
<td>BMJ</td>
<td>British Medical Journal</td>
</tr>
<tr>
<td>WCPT</td>
<td>World Congress of Physical Therapists</td>
</tr>
<tr>
<td>APA</td>
<td>Australian Physiotherapy Association</td>
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<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
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Publications


CHAPTER 1: Introduction

Informed Consent: The research context

“The Opinion (Cardozo J.):

In the year 1771, by royal charter of George III, the Society of the New York Hospital was organised for the care and healing of the sick…

To this hospital the plaintiff came in January, 1908… She became an inmate of the hospital, and after some weeks of treatment the house physician, Dr Bartlett, discovered a lump… He consulted the visiting surgeon, Dr Stimson, who advised an operation. The plaintiff’s testimony is that the character of the lump could not, so the physicians informed her, be determined without an ether examination. She consented to such an examination, but notified Dr Bartlett, as she says, that there must be no operation. She was taken at night from the medical to the surgical ward and prepared for an operation by a nurse. On the following day ether was administered, and while she was unconscious a tumor was removed. Her testimony is that this was done without her consent or knowledge… Following the operation, and, according to the testimony of her witnesses, because of it, gangrene developed in her left arm; some of her fingers had to be amputated; and her sufferings were intense…

In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent, commits an assault, for which he is liable in damages… She had never consented to become a patient for any purpose other than an examination under ether. She had never waived the right to recover damages for any wrong resulting from this operation, for she had forbidden the operation.”

In healthcare, the concept of self determination is found in the legal and ethical obligation to obtain patients’ informed consent to treatment. The notion that a person as an autonomous being has a right to decide whether or not to be subjected to physical interference and that medical treatment might not be performed on them without their consent is the law in Australia, England and in the United States. In America, informed consent is referred to as a doctrine and based upon a patient’s right of self determination as expressed by Cardozo J.

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1 Schloendorff v Society of New York Hospital, 105 NE 92 (New York Court of Appeals 1914), p 93.
above and in many cases since. In Australia, the term is defined in legal terms as the duty to inform patients of risks, benefits and alternatives prior to treatment.

Informed consent has its foundation in ethical theory. From a moral point of view, and in the healthcare context, informed consent is concerned with autonomous choices of patients. The central focus of the bioethics literature has been on the meaning and elements inherent in respect for patient autonomy and autonomous decision-making. Faden and Beauchamp propose three conditions of autonomous action as necessary criteria for a patient’s consent to treatment to be regarded as ‘informed consent.' They are conditions of intentionality (the consent must involve the intentional giving of permission); understanding (a patient must agree to an intervention based on an understanding of relevant disclosed information) and non-control (the consent must be free from coercive or controlling influences). These conditions emphasise that informed consent is about patients having the option to choose, rather than being required to accept a course of conduct proposed by a health professional.

The law in Australia has evolved based upon duties of care owed to the patient to prevent injury. It gives recognition to respect for a patient’s autonomy and autonomous choice in the context of how such choice impacts on any subsequent preventable injury to a patient. Although based upon the principle of self determination, legal requirements delineate an obligation to make disclosures rather than require understanding of ethical theories underlying and ethical meaning inherent in obtaining informed consent.

Taken together, the legal and ethical dimensions of informed consent entail a process of decision-making. Purtilo suggests that this process of informed consent may be regarded as

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2 Landmark cases in North America include *Canterbury v Spence*, 464 F.2d 772 (US Court Appeals, DC Circ 1972); *Natanson v Kline*, 354 p 2d 670 (Kansas Supreme Court 1960); *Reibl v Hughes*, 2SCR 880114 DLR 3d (Canadian Supreme Court 1980).

3 The landmark case in Australia, to be discussed in chapter two is *Rogers v Whitaker*, (1992) 175 CLR at 489; See also Skene, L. (1998). *Law and Medical Practice: Rights, duties, claims and defences*. Sydney: Butterworths, p 78.


a professional ‘tool’ or ‘vehicle for protecting a patient’s dignity in the healthcare environment.’

Throughout this thesis, I will refer to the term ‘informed consent’, or the ‘process of informed consent’ as an overall term that encompasses the positive duty to disclose adequate information; to ensure the patient has sufficient understanding; and to enable a patient to voluntarily give their consent and contribute their choice to any proposed treatment or treatment program. By defining the topic in this way I am combining the ethical theoretical approach with that which the law requires. Both require recognition in clinical practice.

Some authors distinguish between the meaning of the terms morality and ethics. For example, van Hooft et al. define morality as ideas and beliefs about what is right or wrong based on our general upbringing. Ethics on the other hand, according to these authors, refers to ‘a system of ideas about right and wrong’ (such health professions’ codes of ethics) ‘which have been thought about and consciously adopted.’ In this thesis I will mostly use the terms ethics or ethical and where the term moral is used, I will take the standard approach in philosophical writing which is to regard ethical and moral to be equivalent in meaning.

Whilst the ethical issues surrounding the concept of informed consent have been influenced by the development of the law, and the law has in turn been influenced by ethical debate, distinctions can be made between the law’s focus and interpretation of informed consent, and the focus of the ethical literature. From the perspective of ethical theory, informed consent represents a manifestation of the principle of autonomy, whereas the legal view derives from concepts of rights and duties. This research examines what occurs in physiotherapy practice in the context of ethical theories and legal obligations, both of which are identified and explored. Because I take actual clinical encounters as the focus of

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11 van Hooft, S., Gillam, L., & Byrnes, M. (1995), p 187. These authors acknowledge that the distinction between morality and ethics is at times useful. However at other times, it may be useful to use the terms interchangeably. In this thesis, it is more useful to adopt this latter approach.
qualitative examination of the topic, the research draws on what Swisher refers to as a social scientific perspective.\textsuperscript{14} That is, one which is concerned with the concrete personal experiences of implementing informed consent in a clinical context.

The following comments reflect a person’s personal perspective of the process of informed consent. They suggest there is much more to informed consent than a visible framework meeting specified ethical criteria and legal obligations, and they highlight a need to include personal interpretation and perspectives in a consideration of how theory interacts with practice of the informed consent process:

> Informed consent is dependent as much on how we feel in conversation, our relationships with those giving information, how information is given, as with the substantive content of what we are actually told. Informed consent is volatile, emotional and processual. People make up their minds, change, hold on, become confused, disagree, rationalise, blame, accept responsibility, reinterpret, misinterpret, do cost-benefit analyses and then act on what their emotions instruct them to do instead, or do not act, and simply do not know what to do.\textsuperscript{15}

These observations suggest that from the patients’ perspective (or in this case a patient’s family member, looking on), how people think about informed consent will have an impact on their behaviour.

My contention and underlying rationale for this study derives from the other side of the clinical encounter. I contend that the position of the health professional in understanding the complexity and different strands of the informed consent process is similarly important. They are the person who sets the communicative agenda, the person who instigates the process of informed consent. It is therefore important to examine how they reflect and draw upon the conceptual and complex meanings and influences that underpin the more concrete obligations to act.

In this research I investigate the issue of informed consent from two overall perspectives. The first concerns its basis in the ethical theory of autonomy and its interpretation by law and health professional guidelines. The second involves an empirical examination of its occurrence within the communicative interaction between a physiotherapist and their


patient, and its interpretation by physiotherapists. I use qualitative research methods involving analysis of individual audiotaped treatment encounters in private physiotherapy practice and subsequent interviews with the treating physiotherapists.

A central tenet of the study is that the translation of both legal and ethical criteria into the context of the clinical encounter requires a process of negotiation and communicative interaction between the patient and health professional. This research seeks to understand this process, and the factors that influence it in the specific context of physiotherapists working in the physiotherapy private practice encounter. Although obligations of informed consent initially arose in the context of medical practice, the focus in this research is in the area of physiotherapy practice.

There are two main aims of the research. The first is to investigate physiotherapists’ knowledge, attitudes and communicative practices in relation to provision of information to patients and obtaining their informed consent to treatment. The second is to examine the relationship between their communicative actions and ethical notions and meanings of patient autonomy.

**Informed Consent and Physiotherapy**

Physiotherapy or physical therapy\textsuperscript{16} practice is an area of allied healthcare that is concerned with restoration of physical function, and treatments involve application of physical therapy, electrotherapy and advice.\textsuperscript{17} Physiotherapy practice has aligned itself with the practice of medicine from its inception.\textsuperscript{18} Like medicine, physiotherapy/patient relationships have historically been rooted in the medical principle of beneficence and non-maleficence.\textsuperscript{19} Similarly the purpose of communication with patients has traditionally been seen in light of its application to enhance clinical beneficence.

\textsuperscript{16} Throughout this thesis I will use the terms physiotherapy or physiotherapists. However the terms physical therapy and physical therapists will sometimes be used when referring to writers from North America, where physical therapy practice is the equivalent term to the English and Australian term physiotherapy practice.

\textsuperscript{17} Higgs, J., Refshauge, K., & Ellis, E. (2001b). Portrait of the physiotherapy profession. *Journal of Interprofessional Care, 15*(1), 79–89.


Physiotherapy treatment involves physical contact between therapist and patient and physiotherapists are concerned with teaching patients self-management strategies such as exercises, postural adjustment, and fitness advice. Necessary components of this active treatment are patient understanding, motivation and a willingness and ability to contribute and cooperate with the aims of the treatment. I contend the patient-to-clinician information exchange process is as important for the physiotherapist as the doctor, and in some instances, where treatment effectiveness relies upon patient understanding and compliance with exercises and advice, the information exchange process in the physiotherapy encounter may be even more significant. In addition to this treatment focus, physiotherapists as primary practice practitioners, have many of the traditional diagnostic and prescriptive roles of the doctor and they are also directly accountable to their patient.

The Australian physiotherapy profession acknowledges the importance of both the process of informed consent and the ethical ideal of patient autonomy in the ethical principles published by its representative body, the Australian Physiotherapists Association (APA). The interpretation and significance of patient autonomy has been discussed on the basis of its prima facie status (alongside other biomedical ethical principles of beneficence, non-malificience and justice) in physiotherapy literature concerning physiotherapy ethical practice. The basis of information disclosure and obtaining informed consent has been referred to as part of an ethical duty based on the principle of autonomy.

The need for and significance of informed consent has recently arisen in the context of physiotherapy treatment shown to contain an element of risk; that is, manipulation of the

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23 Here the physiotherapy profession has relied upon the four biomedical principles proposed by Beauchamp, T., & Childress, J. (2001).
cervical spine.\textsuperscript{26} The need for informed consent for this treatment and the professional practice guidelines which have been developed as a consequence, have focused on the legal duty to avoid harm by providing practitioners with guidance as to the legal requirements for adequate information to be given to patients prior to cervical spine manipulation.\textsuperscript{27} Subsequent physiotherapy research has concentrated on compliance of practitioners with the published guidelines. Such research has demonstrated poor compliance on the part of physiotherapy practitioners, consistent with findings disclosed by medical practitioner studies, which have similarly demonstrated poor compliance with criteria necessary for informed decision-making.\textsuperscript{28}

In their book, \textit{Informed Consent, Legal Theory and Clinical Practice}, Appelbaum et al.\textsuperscript{29} noted the general absence of a solid foundation amongst medical practitioners of the basis underlying the obligation to obtain informed consent:

Most physicians and other professionals who are affected by the legal requirements for informed consent recognise that there is some legal obligation to talk with patients and obtain their agreement to proposed treatment. But often their knowledge of the details is a mixture of myth and misunderstanding. Few healthcare professionals are aware of the ethical principles underlying the ideas of informed consent.\textsuperscript{30}

Although physiotherapy literature has recognised the importance of respect for patient autonomy as the ethical and legal basis for providing information to patients, there is

\textsuperscript{26} Di Fabio, R. P. (1999). Manipulation of the Cervical Spine: Risks and Benefits. \textit{Physical Therapy}, 79, 50-65. In this paper, manipulation of the spine is defined as a form of manual therapy involving displacement of a vertebral joint by the use of a high-velocity thrust technique. The most frequently reported injuries involve injury to the vertebral artery or lesions of the brain stem. In this authors’ review, physiotherapists were involved in 2\% of the cases of injury.


evidence that physiotherapy practitioners, like their medical colleagues, are still uncertain or at least lukewarm in regard to its implementation in practice.\textsuperscript{31}

Whilst there is general agreement amongst healthcare practitioners on the broad conditions set out by Faden and Beauchamp, of intentionality, understanding and non-control,\textsuperscript{32} required to satisfy compliance with obtaining a patient’s informed consent to treatment, there is very little evidence of how healthcare practitioners actually go about obtaining consent from their patients. This includes the factors that influence their understanding of the meaning of and need to obtain patients’ informed consent. This paucity of evidence is particularly so in the area of allied health and specifically in physiotherapy practice.

Previous studies of physiotherapy communicative actions in clinical practice have shown that physiotherapists value the role of giving patients educative information\textsuperscript{33} and consistently provide such information.\textsuperscript{34} Other studies have shown that communicating clinical information is premised on and valued for its effect in gaining the compliance and cooperation of patients.\textsuperscript{35} These studies suggest that the practice of providing information to patients and implicitly or explicitly obtaining their consent may be based on clinical outcomes of patient co-operation and compliance, rather than being motivated by either the ethical ideal of promoting or enhancing patient autonomy, or the related legal ideal of sufficient material information to allow for meaningful patient decision-making. There has


been little study undertaken of how the concept of informed consent is understood by physiotherapists and how their interpretation of the basis of and need for informed consent influences its implementation within the communication that occurs in clinical practice.

In this research I investigate these issues, focussing upon private physiotherapy practice in Australia where patients may directly present for treatment or may attend for treatment following a referral by a medical practitioner.

Underlying assumptions and theoretical stance

The nature of this research is qualitative. The data comprises seventeen transcripts of both audiotaped treatment encounters and interviews with the participating physiotherapists. The two related ontological frameworks or approaches that underpin this enquiry are based on the assumption that knowledge or reality is both constructed and interpreted.\textsuperscript{36} From a constructivist perspective, knowledge may be built or understood socially, experientially, culturally or influenced by the context of a group.\textsuperscript{37} Translated to this thesis, my examination and construction of knowledge about the process of informed consent is based on an acknowledgement of the range of influences that could potentially impact on physiotherapists’ clinical communication. This necessitates an examination of what aspects of ethical theory inform and guide physiotherapy practice based on a review of both bioethical and physiotherapy-based ethical literature, and an examination and interpretative analysis of therapists’ understanding, interpretation and implementation in clinical practice.

The interpretivist approach presumes that knowledge ‘comprises constructions arising from the minds and bodies of knowing, conscious and feeling beings’.\textsuperscript{38} An interpretive inquiry focuses on the activities of humans situated within a particular context and related to the broader contexts of institutions, histories and accounts.\textsuperscript{39} The object of this research is to discover meanings and understandings attributed by therapists themselves to their clinical

communication. In accordance with the interpretive approach my understanding and subjective biases as the researcher interpreting both the literature and the responses and interactions of participating therapists as outlined above are important.

**Informed Consent: my interest as a physiotherapist/researcher**

I chose this research topic initially because of my interest in the general area of communication and more specifically, the motivations and values underlying clinical communication. As a clinician mostly working as an employee in private practice in Australia for 20 years, I developed an interest in the way that uncertainty was communicated to patients particularly as it related to diagnosis and treatment. The idea that patients presented with a problem and that as the treating physiotherapist I was meant to solve it, weighed heavily. I found that many patients presented with problems which were complex and not easily solved by the application of manual physical therapy and/or exercise advice in a thirty minute treatment session.

In 2000, I completed a Masters in Manipulative Therapy, a clinically-based masters focussing on musculoskeletal physiotherapy and clinical reasoning. This postgraduate study gave me increased confidence in clinical diagnosis and reasoning, but did not stop the questioning related to the inherent uncertainty within many clinical encounters. I felt that there should be greater professional discussion about the complexity inherent in the physiotherapy/patient relationship, rather than the educational and professional practice emphasis on distillation and reduction in the approach to assessment of patients’ physical symptoms, diagnosis and treatment.

In 2001, I completed a Masters in Health and Medical Law. This postgraduate study alerted me to broader expectations of clinical relationships and issues of accountability on the part of physiotherapists as health professionals. Other influences were associated with personal encounters with medical practitioners where the level of explanation and equality of relationship, so clearly expected by legal guidelines and ethical theory, were deficient.

As a teacher in the School of Physiotherapy, I was motivated to research and then introduce an expanded view of physiotherapy, rather than a view which was predominantly bio-
medical in approach. I wanted to be able to provide students with greater evidence of the complexity of clinical practice, and of what it means to establish a therapeutic relationship.

For the past five years I have been a member of the Physiotherapists’ Registration Board of Victoria. One of the Board’s roles is to receive, investigate and determine complaints made against physiotherapists in this state. Failure to effectively communicate lies at the heart of many of the complaints.

My interest and influence on the research question derives from past practical clinical experience and my knowledge of the theory of physiotherapy practice based on postgraduate study in manipulative therapy and health and medical law. These interests developed into a curiosity about how other physiotherapists go about weaving demands of legal and ethical accountability, and establishing authentic relationships within the complex context of the clinical encounter. My background, prior knowledge and preconceptions are therefore interconnected with the aims and development of the research question.

**Scope and Overview of the research**

The research is limited to an examination of physiotherapists’ communication through interviews and treatment audiotape. Patients’ responses and their communication are not focussed upon except to examine those responses within an analysis of the clinical interaction. Focussing upon the physiotherapist and not upon the patient is done for two main reasons. First, there is very little research that has examined the clinical communication practices of physiotherapists in private practice settings. Second, and related to the first, I contend there is a need to have a thorough understanding of therapists’ practices, including the values and goals of practice and their potential effect in the clinical encounter on patients’ ability to contribute, before examining the actual effect on patients.

The research is divided into two broad examinations. The first is an analysis of the ethical and legal meaning of informed consent. From a theoretical and philosophical perspective, I examine how this meaning could and should impact on physiotherapy practice so as to result in a meaningful and integrated approach to the process of informed consent. This analysis of the ethical and bio-ethical literature and theoretical discussion of its relevance to clinical physiotherapy practice paves the way for the empirical examination of what is in fact
occurring in practice, and how that practice relates or does not relate to such ethically-based models and ideals of ethical clinical practice. Figure 1 provides a diagrammatic representation of the overall research design.
Chapter 1 - Introduction

Figure 1-1: Overall design of research

Background to Research Question
- Changes to law of informed consent
- Development of medicolegal and biomedical ethics
- Personal frame of reference and knowledge base

Research Questions
What is the perceived importance of informed consent in clinical practice from physiotherapists’ perspective?
What information do physiotherapists give to patients within a single treatment encounter?
How do physiotherapists communicate with their patients?
What is the relationship and interaction between ethical theories and obligations and the contextual demands of the private practice clinical setting?

Phase 1 (Chapters 2-4)
Define informed consent
- Review and analyse underlying ethical theory of autonomy.
- Review law relating to informed consent.
- Discuss models of practice (for medical practice) linking ethical theory to practice.
- Review physiotherapy ethics literature as it relates to autonomy and informed consent

Phase 2 (Chapters 5-8)-Empirical Component
Collect data.
- Distribute and analyse questionnaire about informed consent.
- Audiotape treatments and conduct in-depth interviews with therapists.

Analyse data
- Build a conceptual picture of physiotherapy communication within the private practice context.
- Integrate with phase 1.

Phase 3
- Conclusions and recommendations for future practice.
Chapters two to four set the theoretical framework for the empirical study. In the next chapter, (chapter two), I define informed consent and trace its origins in both law and ethics. I develop an ‘iceberg framework’ or model to guide this definition. Above the surface of the iceberg I discuss the visible behavioural criteria required for satisfactory compliance with legal and professional guidelines, such as provision of information and obtaining patients’ voluntary consent. Below the surface of the iceberg I discuss ethical theory and bio-medical principles of practice which impact on the development of visible criteria needed for a valid informed consent. The ethical theories of autonomy introduce notions of capacity for reflection, freedom to choose and ability to reason as important components of autonomy. On the basis of both underlying theory and elements required for implementation, I define a notion of ‘ethically enriched’ informed consent. My definition of ‘ethically enriched’ informed consent incorporates explicit links to ethical theories of autonomy and it acknowledges the influence of a patient’s actual capacities to make autonomous choices and contributions to decision-making within a treatment encounter.

In chapter three, I examine the discourse relating to informed consent and the ethical concept of autonomy in the medical and related bio-ethical literature. I review five models of informed consent which have been developed for doctors to integrate the ethical theory of autonomy to the communication required in the process of informed consent. The physiotherapy profession has traditionally aligned its ethical and clinical objectives to those of the medical profession, and therefore this literature forms an important element in the overview of informed consent.

I examine and categorise the models according to how they incorporate ethical ideas of autonomy. I use a hypothetical physiotherapy case scenario to apply the models to the clinical context. I establish they are all applicable and importantly, the way they incorporate ideas of autonomy affects their impact on clinical communication. In this chapter, I argue for the ‘conversation model’ of informed consent developed by Katz as the model of informed consent which has the most resonance with the ideal of an ‘ethically enriched’ informed consent. I contend its usefulness as a model stems from its emphasis on how to think about informed consent and its relationship with the theory of autonomy rather than stipulating what actions should be implemented.

In chapter four, I examine the nature and culture of physiotherapy practice including studies of clinical communication and ethical reasoning. I particularly focus on how the physiotherapy literature has developed its understanding and knowledge of informed consent. The results of this review suggest there has been little engagement with conceptual frameworks of autonomy other than to stipulate respect for autonomy as a clinical duty stemming from an individual rights-based and *prima facie* ethical principle perspective.\(^{41}\) I situate this physiotherapy-based knowledge within the overall ‘iceberg framework’ of informed consent presented in chapter two.

Chapter five discusses the overall research design. It marks a turning point in the thesis, where the focus shifts from discussing a framework of underlying theory and definition of the elements of informed consent, to an explanation of the process, methods and supporting methodology of the empirical research. In this chapter, I discuss the overall research design, the overarching methodologies of constructivism and interpretivism and my use of grounded theory as a research approach. I describe two layers of empirical examination. The first consisting of the development and distribution of a questionnaire about informed consent in different areas of physiotherapy practice. The second consisting of audiotapes of seventeen individual treatment interactions, followed by in-depth interviews with participating physiotherapists.

In chapters six, seven and eight I present my analysis of the audiotaped treatment and interviews, beginning with a description of the visible structure and content of therapists’ clinical communication through to deeper layers of analysis. These include an examination of possible meanings, interpretations and effects of therapists’ language and method of communication on patients’ abilities to contribute to the communicative agenda in general and participate in the process of informed consent more specifically.

In chapter six, I identify a consistent structure, pattern, and content of clinical communication which emerges from my analysis of all recorded clinical encounters. The structure accords with the ideals of clinical physiotherapy practice, including the importance of evidence-based practice and a reliance on bio-medical hypothetico-deductive clinical reasoning.\(^{42}\) Based on these

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\(^{41}\) By a *prima facie* ethical perspective I mean that respect for patients’ autonomy has been examined and interpreted on the basis of its standing against other competing ethical principles.

\(^{42}\) The hypothetico-deductive model of reasoning is a process of attending to initial cues (information) from a patient, generating hypotheses and then evaluating the hypotheses to confirm or generate new hypotheses. See Edwards, I., Jones, M., Carr, J., Braunack-Mayer, & Jensen, G. (2004). Clinical Reasoning Strategies in Physical Therapy. *Physical Therapy*, 84(4), 312-330. In this paper, the authors also propose other strategies of clinical reasoning, which will be discussed in chapter four.
findings, I argue that the overall goal of clinical communication in the treatment sessions is to achieve a beneficial therapeutic outcome. I suggest an important consequence of the structure and goals of clinical communication is a type of barrier to the ability of patients to contribute meaningfully to decision-making within the encounter or to provide an autonomous contribution to the treatment agenda. That is, communication that is predominantly focused on achieving a therapeutic outcome effectively inhibits informed consent, especially the process of ‘ethically enriched’ informed consent.

Chapter seven goes behind this structure by examining therapists’ definitions and interpretation of ideals of physiotherapy practice, that is, their role, the role of the patient and the nature of the therapeutic relationship. On the basis of this insight into practice, I examine therapists’ strategies of communication and how they relate to therapists’ ideals and to ideals of an ‘ethically enriched’ process of communication. Therapists characterised the patient/therapist relationship and their role within it as primarily based on beneficence. Patient trust was seen as important in fostering patient compliance and achieving better treatment outcomes. The value of beneficence was more prominent than the value of patient autonomy as an underlying premise of the patient/therapist interaction. Within therapists’ strategies of clinical communication, I identified a ‘discourse of expertise’ and a ‘discourse of responsiveness.’ Both were orientated towards the overarching goal of achieving a therapist-defined therapeutic outcome. The findings in chapter seven provide further support for the idea of an inbuilt clinical barrier to ethical ideals of respect for autonomy gaining precedence or even equal standing over ideals of providing beneficent (and in some cases) paternalistic patient care.

Chapter eight turns to the specific issue of informed consent within the overall content and structure of the clinical communicative discourse. Having presented the overall framework of the structure, content, purpose and strategies of communication in chapters six and seven, in this final findings chapter I focus on the process of informed consent from the perspective of how therapists define informed consent and, on the basis of further analysis of the audiotaped treatment data, how they implement it. I found therapists interpreted the informed consent process as a need to provide explanations to patients about the purpose and effects of treatment. Decisions about, or choices in relation to treatments were described as the work of the therapist. This view correspondingly limited the role of the patient to agreeing implicitly with the treatment agenda as determined by the therapist.
Chapter nine is the concluding chapter. It integrates the iceberg or definitional framework of informed consent with the empirical observations of its occurrence in clinical practice. My key conclusion in examining both the practice of informed consent and the underlying ethical theory of autonomy is that there are two missing ingredients in the clinical communicative interaction within private physiotherapy practice. The first is a conceptually deep and flexible knowledge of the ethical theory of autonomy. That includes how the ethical meaning of autonomy could and should underpin communication both generally and specifically in relation to informed consent in the context of physiotherapy practice. The second related ingredient is an ability to use ethical knowledge in a reflexive and flexible way within the clinical encounter. On the basis of this conclusion I make recommendations for practice.
CHAPTER 2 - Informed consent: Layers of meaning

Introduction

This chapter is divided into two overall sections. The first concerns the idea of informed consent as it is defined in the law, in bioethical literature and in professional guidelines. The second section concerns the ethical theories of autonomy which underpin the more visible criteria of informed consent outlined in the first section.

My overall aim is to provide an overall definitional framework of informed consent. Within this framework, I highlight differences in focus between philosophical concepts and theories that explain what it means to respect autonomy and more practical clinical interpretations and implementation of autonomy within the process of informed consent in practice.

My investigation and construction of a multi-layered definition of informed consent occupies three chapters. In this chapter I define the established elements, professional guidelines, legal obligations and conditions considered necessary for satisfactory implementation of informed consent. I then provide an account of underlying ethical theories of autonomy. In chapter three I examine how ethical theories of autonomy have been used to guide models and practices specifically developed to aid the implementation of informed consent in medical practice. In chapter four I examine the physiotherapy literature and clinical practice discourse from the perspective of how it has interpreted the requirement for informed consent, and its relationship with the theories of autonomy. The common thread linking these three chapters is that they are all concerned with an exploration of the multi-layered definition of informed consent, an examination of how the elements of informed consent have been emphasised and how the ethical theory of autonomy has been linked to these elements.

A definition of informed consent: The iceberg framework

I have developed an ‘iceberg’ model or framework (Figure 2-1) to illustrate the therapist/patient communication from the external or above surface perspective, that is, what is outwardly visible in the clinical encounter, including the influence of professional and legal obligations. The internal or below surface perspective of the iceberg represents the motivating factors and ethical
theories underlying that which takes place above the surface. The iceberg framework provides the underlying basis and context for the empirical enquiry in chapters six to eight.

Figure 2-1 The iceberg model

The tip of the iceberg (layer one) represents the focus of the empirical component of this research, what is visible, what physiotherapists in private clinical practice actually say and do and how they obtain their patients’ informed consent to treatment. Immediately below the tip (layer two) are the acknowledged elements and conditions of informed consent, including those imposed by the law. Those are the elements upon which professional guidelines and codes of conduct for practice are based. Underlying such codes and guidelines is physiotherapy-based literature (layer three). Here I discuss the physiotherapy ethical discourse and how it relates to clinical practice.¹

¹ This layer of the iceberg model is discussed in chapter four, as a prelude to reporting upon the empirical component of the research.
A number of authors writing in the medical literature have developed models of practice relating to the process of informed consent. These models are more than guidelines or prescriptive guides to action. They contain explicit connections with underlying ethical theory. They seek to draw expressly upon underlying theory as the basis for clinical action. I have placed them at level four within the iceberg framework, part above and part below the surface of the water because they represent a genuine linking of the practical clinical encounter with the ethical theories which underpin them. Whilst they are discussed prior to the physiotherapy literature review (layer three) in chapter order, they are placed below in the iceberg model because of their more explicit focus upon and connections with the underlying ethical theory when compared to the physiotherapy literature.

Below the surface of the water but also within the iceberg itself are layers which discuss ethical theories relating to autonomy. Such theories underpin the elements of informed consent. As the ethical theories and models become more specific to health professionals and their procedures of implementing informed consent, so too are they closer to the surface and more directly linked to models of practice, codes of conduct and the actual visible patient/therapist encounter at the tip.

Closest to the surface, I discuss the principles of bio-medical ethics espoused by Beauchamp and Childress, whose focus is to situate and explain autonomy from the perspective of the needs and context of the clinical encounter. At layer six, I discuss theories specifically developed to explain the concept of autonomy, by Young and Dworkin. These theories are derived from the overall normative ethical theories in the layer below and they highlight how a theoretical understanding of autonomy might impact on the process of informed consent. At the deepest level of the iceberg (layer seven), I discuss the foundational theories of Kant and Mill.

My use of the iceberg framework is designed to illustrate how informed consent may be defined and interpreted in two broad ways. The first is from a global perspective, that is, taking aspects of each layer of the iceberg and recognising the interrelationship between the different layers. The

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second is by relying on one particular layer as the primary basis for understanding and implementing the informed consent process.

In the bioethical literature, definitions and interpretations of informed consent reflect the different emphases or layers of the iceberg framework. For example, Faden and Beauchamp conceptualise the process of informed consent in two ways, with different factors providing the impetus for the obtaining of informed consent.\(^7\) The first way involves an interaction driven by an understanding of informed consent as a ‘special kind of autonomous action’, a process which they call ‘autonomous authorisation’.\(^8\) This approach explicitly incorporates the underlying ethical theory of respect for autonomy as the basis of action. The process of informed consent according to this conception reflects an interaction between the ethical theories below the surface and the clinical encounter at the tip of the iceberg. Their second conceptualisation of informed consent posits as the key ‘drivers’ of informed consent, institutional policies, rules and professional guidelines formed by ‘the demands and influences of social and professional practices, institutional contexts, rules, policies and standard practices.’\(^9\) In this latter approach the underlying influence upon and motivation for obtaining informed consent is less informed by ethical theory and more reactive or responsive to specific contextual demands. In the iceberg framework this scenario reflects an interaction between level two, the accepted elements and legal requirements and the tip of the iceberg, with little if any interaction with layers below.

Gert, Culver and Clouser refer to informed consent explicitly influenced by ethical theory, the equivalent of Faden and Beauchamp’s first approach, as ‘ideal consent.’\(^10\) They similarly distinguish between this ‘ideal’ or conceptually deep notion of informed consent and a superficial focus on the elements of informed consent.

I contend that it is superficial merely to describe what is visibly and consistently required for informed consent without probing the foundations underlying accepted elements. Therefore, to understand and define informed consent as a preliminary step to examining its incidence and manner of occurrence in physiotherapy clinical practice, it is necessary first to give definition to the component parts and conditions that are acknowledged to be relevant to the process of obtaining informed consent. Second, it is necessary to have regard to factors which have been

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7 Faden, R., & Beauchamp, T. (1986), p 276 in their writing refer to the different ways as ‘senses.’
influential in forming those elements, including the law. Third, and most importantly, it is necessary to focus attention upon the ethical theories that underpin the elements of informed consent.

I begin with the assumption, made previously by others,\(^{11}\) that understanding and reflecting upon underlying ethical theory can make a material difference to the ways and means of obtaining a patient’s informed consent to treatment in clinical practice settings. My examination involves an analysis of how the deeper layers of the iceberg inform the superficial or above-surface layers, specifically how philosophical theories of autonomy are interpreted and incorporated within physiotherapy clinical practice criteria related to informed consent. My examination therefore aims to assess the validity of the assumption that knowledge and incorporation of ethical theory makes a qualitatively significant difference to the implementation of informed consent in clinical interactions.

Faden and Beauchamp\(^{12}\) discuss the history and theory of informed consent by first examining the moral foundations and then moving to its foundations in legal theory. In this chapter I trace a different path, focusing first on the most visible and recognisable elements of informed consent and their development and emphasis in law and then I discuss the moral foundations. Sections 1-1, 1-2 and 1-3 below are all components of the second layer of the iceberg because they represent the visible interpretation and ways of implementing the process of informed consent through case law, within healthcare practice and through empirical studies examining its occurrence.

My rationale for beginning with the development of informed consent in the law is because it is the law that has been the catalyst for changes to medical and physiotherapy practice in the area of information disclosure and obtaining patients’ informed consent to treatment.\(^{13}\) The standards of disclosure set down by the law are relatively clear and are used as specific building blocks to

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\(^{11}\) See for example, Hope, T., Savulescu, J., & Hendrick, J. (2003). Medical Ethics and Law. The Core Curriculum. Edinburgh: Churchill Livingstone, p 24. These authors suggest that reasoning about morality in general involves continual moving between moral responses to specific situations and moral theories. See also Dworkin, G. (1988), p 100. Dworkin discusses the importance of becoming clearer about sources of principles and judgments as being both theoretically and practically relevant.


guide professional guidelines and professional ethical conduct. Accordingly, I begin my discussion of the second layer of the iceberg by outlining the elements of informed consent, followed by their legal origin. This includes malpractice law in America and Canada and negligence law in Australia and England.

Section One

The elements of informed consent.

Table 2-1 is a list of the five elements or components of informed consent consistently found in the legal, philosophical, bioethical and professional practice literature that has an interest in the process of informed consent. These elements make up the core content of the second layer of the iceberg model. They represent a description of what should ideally occur at the level of observable communicative practice. Importantly the list is potentially the only source to which most healthcare practitioners have access, to inform their understanding of the obligation to obtain informed consent in clinical practice.

Beauchamp and Childress divide the five elements into three groups: pre-conditions, information elements and consent elements. According to these authors, competence and voluntariness from the patient’s perspective form the necessary pre-conditions to enable satisfactory implementation of both the information elements (which may consist of information, a plan of action and the understanding of both) and the consent elements (such as a decision in favour, decision against and authorisation of a plan). Other authors have divided the five listed elements more broadly into ‘information’ and ‘consent’ components, combining what Beauchamp and Childress treat as the preconditions with the consent component. Purtilo, writing for physiotherapists, combines the same five elements but treats them as indicators of two separate

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dimensions of informed consent, divided according to the respective roles of therapist and patient. On the one hand, a disclosure dimension, completed by the health professional and comprehensible to the patient. On the other, a consent dimension, completed by the patient and given voluntarily based upon comprehension.

Table 2-1: Elements of informed consent. 19

1. **Disclosure** – refers to a core amount of information, including facts or information material to a patient’s choice to consent to a proposed treatment and information that a professional considers material including their recommendation and the purpose of seeking consent.

   Disclosure also relates to standards upon which disclosure should be based. These include the professional practice standard, determined by the community’s customary practices; the reasonable person standard, determined by reference to a hypothetical reasonable person; the subjective standard, determined by the specific informational needs of the individual person.

2. **Comprehension/understanding** – is sufficient if a person has pertinent information about the proposed treatment, and has justified relevant beliefs about the nature and consequences of their actions.

3. **Voluntariness** – refers to the degree that a person wills the action without being under the control of another’s influence.

4. **Competence** – refers to the ability to perform a task and is dependent on how the person’s abilities match the particular decision-making task to be confronted.

5. **Consent** – refers to the agreement, voluntarily given, on the basis of relevant understanding. It may be written, verbal or implied.

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Legal account of informed consent

Before the development of case law dealing with information disclosure in medical practice, information was given so that patients could prepare for eventuality, rather than make a choice. In *Slater v Baker and Stapleton* in 1767 the basis upon which medical practitioners ought give advice and information to the patient prior to a medical procedure was described by the Court as follows:20

> It is reasonable that a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation to enable him to undergo the operation.

The need for the patient to ‘take courage’ was overtaken in the United States Courts early in the twentieth century by the rather more enlightened view that the patient might have some role in deciding whether or not to undertake the procedure for which ‘courage’ was needed. In the landmark case of *Schloendorff v. Nathanson* (cited in the introduction of this thesis) the Court of Appeals of New York stated the oft quoted phrase that ‘every human being of adult years and sound mind has a right to determine what shall be done with his own body’.21

In the mid-1950s the legal doctrine of informed consent emerged from American Common Law with recognition by the American Judiciary of a legal right to information as part of the principle of self-determination. The term ‘informed consent’ first arose in North America in 1957 in *Salgo v Leland Stanford Jr University Board of Trustees*.22 The Californian Court of Appeal stated that patients needed to know certain information before they were able to choose between treatments and consent to the treatment. The Court said that the required information included the nature, consequences, risk, benefits and alternatives to any proposed treatment. This standard became known in the United States as the ‘reasonable person standard of disclosure’.23 It obliged the healthcare practitioner to disclose what a hypothetical average person would want to know before they gave their consent to treatment.

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20 *Slater v Baker and Stapleton*, 2 Wils 359 (KB 1767). In this case, the patient alleged that the surgeon and his assistant unskilfully re-broke his leg to improve the alignment and callous formation without his consent. Whilst the Court suggested that this complaint was really a trespass in law, they commented, as quoted above, on the reasons in general, for provision of information to patients by the medical profession.

21 *Schloendorff v Society of New York Hospital*. See note 1, Chapter one.


23 *Salgo v Leland Stanford Jr. University Board of Trustees*, See also *Canterbury v Spence*. 
Following the United States, in other English speaking jurisdictions notions of a duty to obtain informed consent were slower to develop, with Canada\textsuperscript{24} taking the lead, Australia\textsuperscript{25} and New Zealand\textsuperscript{26} drawing upon its experience, and England\textsuperscript{27} not quite making the jump to a legal position which more or less equates to that in the United States. In Australia, there have been no cases about informed consent involving physiotherapists. However as physiotherapists are health professionals with primary practitioner status, they are subject to the same standards of care set down by the law as all other health practitioners.\textsuperscript{28}

In Rogers v Whitaker the High Court in Australia embraced the view previously expressed in England in Sidaway v Governors of Bethlem Hospital\textsuperscript{29} that advice constitutes an element of a ‘single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment’. In Rogers v Whitaker the Plaintiff, Mrs. Whitaker, underwent surgery to improve the appearance and possibly the sight of one eye. She had been almost totally blind in that eye since the age of nine. Despite incessant questioning of the surgeon as to adverse consequences associated with the surgery, the surgeon did not warn her of the risk of developing sympathetic ophthalmia which had an occurrence rate of 1:14,000 in her good eye following surgery. The surgery was performed without negligence. The sight however was not restored to the injured eye and the condition of sympathetic ophthalmia led to blindness in the sighted eye.

The High Court held the surgeon liable irrespective of whether the patient sought information, deciding that the surgeon owed a positive duty to provide the information whether it was actively sought or not. In so doing, it referred to several cases in America, Canada and England.

In the American case of Canterbury v Spence the doctrine of informed consent was developed on the grounds that ‘patient’s right to self decision shapes the boundary of the duty to reveal’.\textsuperscript{30}

\begin{itemize}
\item \textsuperscript{24} Reibl v Hughes.
\item \textsuperscript{25} Rogers v Whitaker.
\item \textsuperscript{26} Smith v Auckland Hospital Board, NZLR 191 (NZ CA 1965).
\item \textsuperscript{27} Sidaway v Bethlem Royal Hospital and Maudsley Hospital, AC 871 (HL 1985); Airedale National Health Service Trust v Bland, AC 789 All ER 821 (HL 1993).
\item \textsuperscript{28} See chapter nine, ‘Professional competence and the issue of negligence’ in Kerridge, I., Lowe, M., & McPhee, J. (2005). The authors discuss the tort of negligence and its role in influencing professional standards of care for all health professionals. See also Skene, L. (1990). You, your doctor and the law, Melbourne: Oxford University Press, pp 1-16. The author provides an extensive review of the changes in society and medical practice, including the growth of the health consumer movement in recognising patients’ rights, especially as they relate to self determination and autonomy.
\item \textsuperscript{29} Sidaway v Bethlem Royal Hospital and Maudsley Hospital, p 893 per Lord Diplock
\item \textsuperscript{30} Canterbury v Spence, p 786.
\end{itemize}
important legal precedent in England was the case of *Bolam v Friern Barnet Hospital Management Committee*.\(^{31}\)

According to the *Bolam* principle, as stated by Lord Scarman in the case of *Sidaway* from which the ‘Bolam principle’ emerged:

> 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 adopt a different approach. \(^{32}\)

According to this principle, the medical profession and not the legal profession was recognised as the authoritative source of guidelines and criteria relating to medical information and related patient decisions, rather than specific legal principles and agendas.

By rejecting the *Bolam* principle the Australian Court favoured a position more consistent with the American ‘reasonable patient standard’ of determination. This standard means that a doctor is legally obliged to give their patient enough information and to do so in such a way that a ‘reasonable’ or prudent person, in the particular patient’s position would be able to understand any material risks and benefits of a proposed treatment enabling them to give their informed consent to proceed. Although the American ‘doctrine’ of informed consent was not totally embraced in Australia, the High Court\(^ {33}\) did not also accept the English precedent (the Bolam principle) The High Court held in *Rogers v Whitaker*:

> Except in the case of an emergency or where disclosure would prove damaging to the patient, a Medical Practitioner has a duty to warn the patient of a material risk inherent in proposed treatment. \(^{34}\)

The requirement in Australia that reasonable care must be taken to ensure the patient understands the information, advice or warnings places the onus squarely on the treating practitioner to individually tailor the information. It is not enough merely to proffer the information or advice. The practitioner must also assess patient comprehension of the information: \(^ {35}\)

> The skill is in communicating the relevant information to the patient in terms which are reasonably adequate for that purpose having regard to the patient’s apprehended capacity to understand the information.

\(^{31}\) *Bolam v Friern Barnet Hospital Management Committee*, 2 All ER 118 (QBD 1957).

\(^{32}\) *Sidaway v Bethlem Royal Hospital and Maudsley Hospital Board*, p 881.

\(^{33}\) *Rogers v Whitaker*, p 479.

\(^{34}\) *Rogers v Whitaker*, p 479.

\(^{35}\) *Rogers v Whitaker*, p 490.
In a further case in the High Court in Australia, *Rosenberg v Percival*, the High Court confirmed the view that decision-making within medicine must be a shared exercise in which health care practitioners are obliged to take active steps to ensure that patients are empowered to make their own decisions about important procedures to be undertaken on their bodies.

Obtaining the patient’s signature on a form or providing a written explanation of the risks may not be sufficient to discharge the legal duty in Australia. In *Rosenberg v. Percival*, Kirby J. specifically commented on the sufficiency of provision of written information about risks to patients. His Honour’s view was clearly that personal, one-to-one communication based upon an actual interchange of information in a way likely to be understood and actually appreciated by the patient, is necessary for the legal obligation of the practitioner to be discharged.

In summary the legal requirements relating to obtaining patients’ informed consent as outlined in *Rogers v. Whitaker* and *Rosenberg v. Percival* are:

1. The treating health care practitioner has a positive duty to inform patients of the risks, benefits and alternatives of any treatment procedure.

2. The information that is required to discharge the above duty, will vary, depending on what is material to the patient. In *Rosenberg v. Percival*, Gummow J. noted that in judging the seriousness of the potential injury, it is the perspective of the plaintiff which is important.

3. Health care practitioners can not rely on standards set or recognised by the profession as protection against breaches of the duty to inform. Evidence of accepted practice is useful for the Courts, but the determination of each case will depend on the views adopted by the Court as to what is required to discharge the duty given both the relevant risk and the particular patient’s characteristics.

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36 *Rosenberg v Percival*, 205 CLR 434 (HCA 2001). In this case, a dental surgeon was sued by his patient for failing to advise her beforehand of the risks inherent in the surgery. The patient suffered severe and disabling pain following surgery to her temperomanibular joint (jaw).


38 *Rosenberg v Percival*, p 761.


40 *Rogers v Whitaker*, p 489.

41 *Rogers v Whitaker*, p 490.

42 *Rosenberg v Percival*, p 747.

43 *Rogers v Whitaker*, p 487.
4. A risk may be regarded as a material risk if a reasonable person would attach significance to it or if the health practitioner would, or should be aware that the particular patient would attach significance to it.\(^{44}\)

**Professional response to the law.**

The response and consequent interpretation of the changes required by the law relating to informed consent amongst health professionals has more or less followed the expected range of reactions to regulation seen to be imposed from an external source, namely:\(^ {45}\)

1. self justification or denial of the possibility of change;
2. resistance to its requirements;
3. exploration of how to achieve the change; and
4. commitment to the change.

Examples of the first two reactions may be found in doctors’ protests about the imposition of the law on their territory of health practice, and resistance to implementation of its requirements. Faden and Beauchamp\(^ {46}\) refer to the medical commentary in the 1970s in America as largely negative. Their review of the medical literature included articles that ranged in tone from serious critique to ‘caustic parody’.\(^ {47}\) The following quote from a doctor provides an example of both denial and resistance to change:

> 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.\(^ {48}\)

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Doctors found a number of reasons to resist the idea of informed consent. Responding to a paper outlining the law relating to informed consent in Australia, a London anaesthetist wrote:

If I am obliged to inform all patients of such rare occurrences then 14,000 patients will be worried pre-operatively for each complication occurring... some patients may refuse the benefit of surgery due to a failure to understand the concept of risk.  

Other writers have observed that, in general, scientists and doctors resent imposed regulation as ‘an unnecessary impediment to their creativity, a slight on their judgment and an attack on their patients’. This is not a surprising response given that several empirical studies which have examined doctors’ interpretation of the required legal standard have disclosed a misapprehension amongst doctors of what is required. In Australia, a survey in 1997 of doctors after the judgment in Rogers v Whitaker indicated that many doctors did not know about or misunderstood their legal obligations. A study of 336 Australian doctors in 2000 showed that almost half incorrectly believed they had to disclose all risks regardless of remoteness or gravity, and in 2001 Darvall et al. demonstrated that two thirds of doctors had this incorrect belief.

In Australia, a range of responses have highlighted on the one hand concern for the over-demanding criteria of informed consent and territorial infringement of law on medical practice.

On the other hand, some writers (mostly lawyers) have canvassed the possibility of a positive impact from requirements of the law relating to informed consent on the practice of medicine.

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49 Young, P. (2002). What is reasonable informed consent? Rapid response to informed consent: lessons from Australia. BMJ, p 40. In making this comment, the surgeon was referring to the case of Rogers v Whitaker where there was a risk 1:14000 of developing sympathetic ophthalma.


55 In contrast to the previous note, all the following papers suggest that law can play a positive role in influencing medical practice. Darvall, L. (1993). Consent to medical treatment. In L. Darvall (Ed.),
Exemplifying the first group Gerber, a practicing doctor, responded to legal developments by writing about the amount of information a consent form would require, suggesting it would include ‘the kitchen sink as well as every other known, unknown or suspected risk’. On a sample ‘consent form’ for an angiogram, Gerber included the following:

“It is clearly impossible to list all possible complications, which would have to include the possibility of an earthquake, the flooding of the Brisbane river, or that the hospital is struck by lightning.”

In contrast, Jones, an English professor of law suggested that whilst the law relating to informed consent provides little practical guidance to doctors, ‘the iterative process between case law and professional guidance may, in time, create a more substantive ‘right’ to truly informed consent for patients.’

Some legal commentators are doubtful that legal pronouncements can affect medical practice to any major extent at all. This seems to be particularly the case where the legal doctrine involves subtle issues like communication and dialogue. Katz, for example, observed that judicial orders could at best ‘prod doctors’.

For the medical profession in Australia, much has been written about the implementation of informed consent. The focus of this literature has been on how health professions should comply with duties of disclosing information, what information to disclose, and how to obtain

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the patient’s consent. This literature, in the form of professional guidelines, provides examples of the second two reactions listed at the beginning of this section, that of exploring how to change followed by a commitment to change.

For doctors in Australia, as a direct response to the 1989 Law Reform Commission Report, the National Health and Medical Research Committee NHMRC published guidelines on providing information to patients for medical practitioners, first made available in 1993 and most recently revised in 2004. The NHMRC guidelines were prepared by a working party of the NHMRC following recommendations made by the Victorian, New South Wales and Australian Law Reform Commissions.

For physiotherapists in Australia, informed consent guidelines in the specific treatment area of cervical manipulation were first published in 1988. The Australian Physiotherapy Association initially developed a protocol detailing the information which should be disclosed and the process of seeking consent for the treatment of cervical manipulation. The protocol has been recently revised, and this revision and associated studies and commentary are discussed in detail in chapter four.

In summary, two main themes emerge in my review of the medical profession’s response to the legal obligations of informed consent. The first is a resentment of or resistance to the impact of the law on the practice of medicine. The second is a type of reactive compliance to its requirements in the form of guidelines for practice. In other words, the primary way of moulding the externally imposed requirement of informed consent into the real context of clinical practice has been to focus on what to do in order to meet obligations but not necessarily to understand or embrace the theoretical source of the elements.

In the next two sections I discuss possible reasons for why the law relating to informed consent has received both resistance and reactive compliance from health professionals. The first reason

63 Law Reform Commission of Victoria. (1989), p 52. In that report it was stated that the majority of patients want more information than they usually receive during medical consultations.
relates to the fact that the elements and requirements of informed consent were externally imposed, and not a natural extension of clinical practice. As a consequence, the emphasis in the reactions and guidelines of medical practice has been on defining obligations of informed consent, rather than seeking to understand and incorporate the underlying ethical theory into clinical ethics. The second reason relates to the relatively narrow focus of the law as the factor that limits its uptake into broader areas of clinical practice.

**Informed consent is external to the ethos of healthcare practice**

The primary historical source of doctors’ understanding of their role in communicating with and relating to patients derives from Hippocratic doctors in ancient Greece. The purpose of medicine as expressed in the Hippocratic oath is to benefit the sick and keep them from harm and injustice. From this basis, the primary goals of medicine were considered to be patient care and professional responsibility. The Hippocratic tradition was carried forward from medieval to modern medicine as an ideal of moral commitment and behaviour. Within this tradition, respect for patient autonomy was not traditionally seen as the guiding force or moral motivation behind medical practice and clinical decisions. Skilled communication in care and deference to patients’ preferences were not included in the Hippocratic tradition, except in so far as dialogue could be used to instil confidence and ‘persuade’ patients to follow a particular therapeutic regime. Prior to the mid-twentieth century, respect for a patient’s autonomy was subordinated to the ideal of achieving medicine’s goals.

The implications of this subordination of autonomy to beneficence meant that responsibilities of disclosure and consent seeking were defined by the greater obligation to provide medical benefits in both clinical practice and research, which surpassed the obligation to respect autonomy. The necessity to give the patient autonomy of decision-making was narrowly understood and defined in terms of the medical benefits which may occur as a result.

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Katz, a leading voice for ethics in the practice of medicine, has long criticised the narrow scope and understanding of informed consent in medical practice, suggesting that:

The history of the physician-patient relationship from ancient times to the present bears testimony to physicians’ caring dedication to their patients’ physical welfare. The same history, by its account of the silence that has pervaded this relationship, also bears testimony to physicians’ inattention to their patients’ right and need to make their own decisions. Little appreciation of disclosure and consent can be discerned in this history, except negatively, in the emphasis on patients’ incapacities to apprehend the mysteries of medicine and therefore, to share the burdens of decision with their doctors. 73

Martin Pernick, 74 an historian, is less critical of the relationship between medical practice and the ideals of informed consent. Pernick suggests that truth telling and consent seeking have long been a part of the medical tradition. Whilst that is his view even Pernick concedes that the nineteenth century views differed from ‘modern concepts of informed consent’ in that they were not rights oriented and were commonly justified by a therapeutic benefits rather an individual rights justification. 75

The notion of beneficence on the part of medical practitioners was also extended to the wider community. It allowed doctors and scientists to engage in medical experiments which either were or were thought to be justified on the basis that they were for the good of society and medical science. 76 The impact of questionable practices in medical experimentation resulted in the

75 Pernick, M. (1982), p 3
76 Beauchamp, T., & Childress, J. (2001), p 428. The Willowbrook case, described by Beauchamp and Childress is a good example of doctors’ notions of beneficence outweighing regard for autonomy and informed consent. In that case, in an attempt to develop immunisation against hepatitis, which was rampant in the Willowbrook State School, an institution for mentally retarded, New York, doctors decided to expose a small number of newly admitted children (750-800 children) to the Willowbrook strains of hepatitis virus. This was done without parents’ informed consent. Although the results of this experiment were useful and ultimately beneficial in determining the period of infectivity of infectious hepatitis, its critics contended that without the informed consent of the parents of the children, the research was unethical from its inception, and its benefits do not counter this fact.
development of responses calling for a review of medical ethics and led to the birth of modern bioethics.\textsuperscript{77}

Prior to the late 1950s, there was little written in the medical literature concerning the issue of informed consent. Faden and Beauchamp refer to an explosion of literature on the subject, partially stimulated by legal cases\textsuperscript{78} and partially by the development of the new concept of medical ethics. The vulnerability of research subjects was highlighted. Mechanisms for protecting individuals from the more powerful professional researchers began to be developed.\textsuperscript{79}

The significant point to be made is that the internal ethos and traditional approach of medical practice (and medical research) has not encompassed ideas of patient autonomy. Where doctors were used to giving sufficient information to patients so that they may be ready to endure whatever the therapeutic intervention might bring,\textsuperscript{80} the law developed a stance on informed consent, based on the rights of patients to make decisions for themselves.

From the perspective that the law is an external force imposed on top of but not necessarily integrated with traditional medical practice ideals, the reactions of health professionals to formulate a set of rules and situations in which informed consent is relevant to clinical practice and to stipulate strategies which emphasise the content of the information to be disclosed, is understandable. However the consequences are that the deeper ethical ideals remain unexamined and external to the goals of clinical practice.

A second reason which has been proposed in the literature to explain the lukewarm or mechanical response by the health professions to the imposition of the law of informed consent, is that the focus of the law itself is too narrow and, as a consequence, provides little real impetus for changing or incorporating the ideals of informed consent into practice.

\textit{Legal focus is too narrow}

In section 1-2, I summarised the legal requirements relating to obtaining a patients’ informed consent to treatment. I highlighted their main emphasis to be on the amount and type of

\begin{itemize}
  \item This was the sentiment expressed in the case of Slater v Baker and Stapleton (1767).
\end{itemize}
information that should be disclosed. Faden and Beauchamp\textsuperscript{81} suggest that disclosure requirements in law stem from the need to develop generally applicable mechanisms of informed consent by which injury and responsibility can be readily and fairly assessed in courts. Moreover the legal emphasis, whilst being premised on a concern for patient self determination, nevertheless emphasises the health practitioner’s role in discharge of duty rather than the patient’s right to autonomous decision-making.

The primacy given to disclosure has been criticised by some authors who would prefer the moral basis or rationale underlying informed consent, an approach which promotes autonomous authorisation by the patient to be a more prominent focus in discussion and implementation. For example, Katz suggests that the court’s single-minded emphasis on the need for health practitioners to disclose information makes the objective of giving patients a greater voice in decision-making virtually unattainable.\textsuperscript{82} He states first in 1977\textsuperscript{83} and again in 2002:

> The law of informed consent is substantially mythic and fairy tale-like as far as advancing patients’ rights to self-decision-making is concerned. It conveys in its dicta about such rights a fairy tale-like optimism about human capacities for ‘intelligent’ choice and for being respectful of other persons’ choices; yet in its implementation of dicta, it conveys a mythic pessimism of human capacities to be choice-makers. The resulting tensions have had a significant impact on the law of informed consent which only has made a bow toward a commitment to patients’ self-determination, perhaps in an attempt to resolve these tensions by a belief that it is ‘less important that this commitment be total than we believe it to be there.\textsuperscript{84}

Echoing these sentiments Kerridge and Mitchell suggest the legal duty to obtain a patient’s informed consent may be missing the point.\textsuperscript{85} They suggest that if the ethical ideal of autonomy was the driver of the law the purpose of the duty would be framed in terms of a doctor being required to take reasonable care to facilitate patient autonomy rather than a narrow interpretation consisting of patients’ authorisation to proceed with a medical intervention.\textsuperscript{86} The broader interpretation by these authors requires a health professional to go beyond providing information in a monologue, and requires them to enter into a dialogue with patients during which mutual understanding and views are explored and clarified. In the words of Katz, doctors must have

\textsuperscript{84} Katz, J. (2002), p 83.
\textsuperscript{86} Kerridge, I. H., & Mitchell, K. R. (1994), p 244.
‘conversations’ with their patients. Such an interpretation also implies that unless Rogers and Whitaker or other legal cases involving disclosure of information are given this broader interpretation by health practitioners they are flawed as a test to protect patient autonomy.

Whilst the law has clearly stated that the underlying purpose of the duty of care in advising patients was to protect patient autonomy, it has not correspondingly examined how autonomy might be protected, other than to stipulate the duty to provide adequate information in a way that enables a patient to make an informed choice. Although Australian law has stipulated the subjective requirement of patient understanding, the emphasis, and as a consequence the response by health professionals, has nevertheless been on health practitioner obligations of disclosure and evidence of consent.

In the next section I move from an examination of professional reactions and possible reasons for those reactions to informed consent, to highlight the focus and nature of empirical studies concerned with how health professionals understand and implement informed consent. The focus of much of the empirical research has been on examining evidence of and compliance with the elements of informed consent in both the research and clinical setting.

**Studies of the elements of informed consent.**

One of the earliest and most comprehensive surveys of doctors’ practices and understanding of informed consent in the United States was commissioned by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research. This involved a parallel study of both doctors and the public as to attitudes toward and methods of implementation of informed consent. The statistics on compliance with the duty to inform patients were superficially impressive. Seventy-five percent of physicians reported that they:

> always or usually explain to their patients the nature and purpose of the recommended treatment, the pros and cons of this treatment versus alternative treatments, the likely side

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87 Katz, J. (2002). See chapter six (pp 130-165), where this idea is discussed more fully using Katz’s ‘conversation model’ of informed consent.

effects, the risks of death or serious disability that have (at least) a 1:100 probability of occurrence, and the probable impact of treatment on the patient’s family life and job.\textsuperscript{89}

That the responses were superficial only and in reality much less impressive than appears at first glance promptly emerges when attention is directed to the response of physicians when asked to define the meaning of ‘informed consent’. Only twenty-six percent of physicians indicated that informed consent had anything to do with a patient giving permission, or agreeing to treatment.\textsuperscript{90} Twenty-three percent of the doctors interviewed identified informed consent as patient understanding of treatment risks, and only eight percent indicated that patient understanding of treatment alternatives was a component.\textsuperscript{91} The majority of doctors (58\%) defined informed consent as a process of informing patients about their condition and recommended treatment.\textsuperscript{92}

An Australian survey of doctors by Darvall et al., nearly twenty years later, found that more than two-thirds of the surveyed general practitioners:

- incorrectly believed that they are required to meet an impossible (and totally impractical) standard of disclosure of all foreseeable risks with a significant minority indicating their uncertainty in relation to this fundamental aspect of clinical practice.\textsuperscript{93}

Similar results have been obtained in surveys of physiotherapists concerning their understanding and implementation of informed consent for cervical manipulation.\textsuperscript{94} These results will be discussed in detail in chapter four.

What is significant in these studies is that there are variations in health professionals’ understanding and implementation of informed consent. The factors which influence the variations are more complex and have not been explored in many of the empirical studies.

In the Harris et al. study, fifty-two percent of doctors reported that at least once per day they find themselves in a situation where they need to make a conscious and deliberate evaluation of how much to tell a patient about his or her condition.\textsuperscript{95} In other words, according to this response, doctors do appear to weigh up the pros and cons of giving particular types of information. The

\textsuperscript{89} Harris, L., Boyle, J., & Brounstein, P. (1982), p 91.
\textsuperscript{90} Harris, L., Boyle, J., & Brounstein, P. (1982), p 151.
\textsuperscript{91} Harris, L., Boyle, J., & Brounstein, P. (1982), p 151.
\textsuperscript{92} Harris, L., Boyle, J., & Brounstein, P. (1982), p 150.
\textsuperscript{94} Grant, R., & Trott, P. (1991).
\textsuperscript{95} Harris, L., Boyle, J., & Brounstein, P. (1982), p 19.
factors that influence this weighing up process comprise knowledge of law, professional ethics, treatment context, personal values and experience.

Most of the empirical studies have focused on the visible elements of the process of informed consent, rather than these underlying factors which inform the weighing up process and which impact on the outward process. For example, since 1990 there have been a number of empirical studies concerned with the evaluation of the information-giving behaviour of healthcare practitioners.96

Sugarman et al.97 published an annotated bibliography of empirical research concerning informed consent for medical treatment and research with older patients and subjects eighteen years of age and over.98 The range of studies listed in their bibliography cover the following elements of informed consent:

1. decision-making capacity (competency to participate in the informed consent process);
2. voluntariness (ability and opportunity to make un-coerced decisions about treatment or participation in research);
3. disclosure (the type of information provided by the clinician, such as information about procedures, risks, benefits and alternatives);
4. understanding (patient’s comprehension and recall of information presented to them);
5. consent or authorisation (the patient’s expression of his/her decision to accept or refuse a proposed procured); and
6. policies and procedures of informed consent (including who obtains consent, how it is obtained and the level of practitioner compliance with policies and obligations).

98 Several of the empirical studies the subject of the Sugarman et al. (1990) bibliography are discussed in more detail in a paper included in Appendix 6 of this thesis. Delany, C. (2002). Cervical manipulation-how might informed consent be obtained before treatment? *Journal of Law and Medicine, 10*(2), 174-186. In this paper I review the literature and use it to guide proposed methods and procedures of obtaining informed consent relating to the physiotherapy practice of cervical manipulation.
Whilst the empirical literature reviewed by Sugarman et al. refers to various aspects of the same list of elements listed by Beauchamp and Childress,\(^9\) and listed in table 2-1 at the beginning of this chapter, the focus of the research has been on the effect and/or method of compliance with its various elements.

A feature of the studies seeking to measure practitioner compliance with processes of informed consent is that whilst practitioners appear to understand and comply with requirements of information disclosure and the recording (either verbally or written) of consent, there is evidence of poor compliance with the elements that require a focus or attention to be paid to the subjective requirements of the patient. A good example of this is a study by Braddock et al.\(^1\) The authors began their study by identifying the elements of practice which in their view constitute ‘ideal’ informed decision-making for the purposes of their empirical investigation of its occurrence. The elements they identify arise from their synthesis of ‘important models of informed consent in bioethics literature’, particularly those authors who advocate greater involvement and promotion of patients in active decision-making.\(^2\) The elements identified by Braddock et al. are:\(^3\)

1. Discussion of the clinical issue and nature of the decision to be made;
2. Discussion of the alternatives;
3. Discussion of the pros and cons of the alternatives;
4. Discussion of uncertainties associated with the decision;
5. Assessment of patient’s understanding; and
6. Asking the patient to express a preference.

Their study involved audio-taping primary care visits and found that although important clinical decisions were commonly made, they were rarely preceded by substantive discussion of elements of ‘ideal’ informed consent. The least frequently included element was found to be discussion of the patient’s degree of understanding.

Although Braddock et al. examined clinical practice by seeking evidence of a number of elements of informed consent, other studies have emphasised certain elements in preference to others. In particular, there has been a focus on examining the type and amount of information disclosed by the health practitioner\textsuperscript{103}, the method of its delivery\textsuperscript{104} and the checking of patient recall with regard to the information.\textsuperscript{105} In other words, the studies have largely been concerned with measuring levels of practitioner compliance and assessing procedures of implementation related to a defined list of elements.\textsuperscript{106} Whilst such a focus is necessary and valid for assessing implementation of legal expectations, I contend that it is superficial to the extent that it emphasises procedures of implementation over understanding of underlying ethical theory. As Faden and Beauchamp suggest, clinicians’ interpretations of compliance with the list of elements of informed consent may mean no more than ‘an empty formality.’\textsuperscript{107}

**Summary of section one**

In summary, in the discussion to this point, I have focussed on the second layer of the iceberg model. I have argued there is general agreement and consistency of application of the list of elements of informed consent within the law, professional guidelines and empirical studies. I have discussed the content and interpretation of that which is visible and known about the procedures and policies of informed consent above the surface.

My claim and the claim implicitly made by the layered structure of the iceberg model is that without an understanding and appreciation of the underlying ethical theory, issues of compliance with the procedural aspects of informed consent will be the dominant framework to which health practitioners will refer when implementing it in practice. The reason that is so becomes apparent when the ethical concept of autonomy is analysed and understood and I suggest there is a danger


\textsuperscript{106} See also two studies in Australia that have examined policies and procedures of informed consent include Dharmamanda, V. (1992), pp. 1-13; Skene, L., & Millwood, S. (1997).

that the assumptions and meanings and (in this case) ethical theories which underpin the list of elements of informed consent will be brushed aside in favour of emphasising and measuring how and whether compliance with the elements has occurred.

I contend on the basis of the discussion in the second half of this chapter that without a sound foundation in the ethical theory of autonomy there can and will be no moral recognition of the patients’ rights and capacities to give their consent as opposed to the healthcare practitioners’ duty to obtain informed consent. In making this contention I draw from the ideas of Kant, who describes the morality of actions to be grounded in the notion of pure reason, and not in externally imposed duties, circumstances and reasons:

It is very beautiful to do good to human beings from love for them and from sympathetic benevolence or to just be from love of order; but this is not yet the genuine moral maxim of our conduct, the maxim befitting our position among rational beings as human beings…we stand under a discipline of reason and in all our maxims must not forget our subjection to it or withdraw anything from it. ¹⁰⁸

In other words, according to Kant, for all people, duty derives from the moral law,¹⁰⁹ or as Spriggs states in her discussion of Kant’s ideas of autonomy ‘there is no moral worth when we act on laws in which our interest is merely extrinsic.’ ¹¹⁰

In section two of this chapter, I have selectively chosen the views and philosophical discussions of a number of philosophers. My aim is to select from major contributions of philosophical ideas about the nature of autonomy and trace a path towards the surface (in the iceberg model), beginning with ethical notions of autonomy and then moving towards their meaning and relevance in the more specific context of healthcare practice.

**Section Two**

*Foundational ethical theories*

The notion of autonomy is honoured in different forms in all major moral theories in the Western analytic tradition.¹¹¹ The theories and positions taken by the philosophers Immanuel Kant¹¹² and

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¹⁰⁹ Kant, I. (1993), p 70.

John Stuart Mill\textsuperscript{115} provide the moral basis, or foundational moral arguments for the principle of respect for autonomy. Kant’s theory of respect for autonomy is grounded in metaphysical considerations of what it means to be a rational agent and to do what is right. Importantly, the reasoning underpinning what is right is a privately understood reasoning. Berg et al. describe the intrinsic and individual nature of Kantian theory as follows:

It is not the consequences of our actions, nor an external set of laws, that determines the ethics of our action. It is recognition of our intrinsic, irreducible, unalienable value as autonomous persons, our dignity beyond price, that provides the supreme moral measure.\textsuperscript{114}

Mill viewed autonomy differently. He was less concerned about the personal processes of the individual. Instead, he focused on the maximisation of utility by allowing an individual to freely (or autonomously) pursue ‘their personal happiness, consistent with allowing others that same right’.\textsuperscript{115} Neither Kant nor Mill discussed ideas of autonomy as they might relate to the concept of informed consent. Their philosophies were not concerned with the elucidation and justification of ‘morality’ in the sense of the rightness or wrongness of health professionals’ conduct. As moral philosophers, they were concerned with more general questions about how ‘one ought to live’ and about what could count as good reasons for ‘acting in one way rather than another’ and ‘what constitutes a good life for human beings’.\textsuperscript{116}

As a practical guide to action, the normative theories of Kant and Mill provide methodologies or ways to approach, think and implement a meaningful concept of autonomy together with suggestions as to the type of attitude to adopt. They provide an ethical structure rather than specific guidelines for practical clinical action.

From these normative theories, I then move to layer six of the iceberg model. Within this layer I discuss the theories of Gerald Dworkin and Robert Young. These authors focus on the notion of autonomy and how it might be recognised or respected in human behavioural terms. Finally, I discuss the views of Beauchamp and Childress, how they define and situate autonomy as a

\begin{thebibliography}{99}
\bibitem{112} Kant, I. (1998).
\bibitem{115} Appelbaum, P., Lidz, C., & Meisal, J. D. (1987), p 24. Mill did not really discuss autonomy directly, but many of his ideas of liberty and choice have been equated with the notion of autonomy.
\end{thebibliography}
principle in the specific context of healthcare and alongside other significant bio-ethical principles.

**Kant**

Autonomy according to Kant is an idea of reason which is attributed to all rational wills. Kant ‘viewed autonomy as a property of the wills of virtually all adult sane human beings, not as a special feature of the most perfectly rational or morally conscientious persons’. The implications of this notion of autonomy as a ‘property’ or human ‘trait’ is that it forms an objective principle or basis of moral duty to respect all human beings. The following quote is one version of this objective principle, or ‘categorical imperative’:

> The ground of this principle is: *rational nature exists as an end in itself*. The human being necessarily represents his own existence in this way; so far it is thus a *subjective* principle of human actions. But every other rational being also represents his existence in this way consequent on “just the same rational ground that also holds for me; thus it is at the same time an *objective* principle from which, as a supreme practical ground, it must be possible to derive all laws of the will. The practical imperative will therefore be the following: *So act that you use humanity, whether in your own or in the person of any other, always at the same time as an end, never merely as a means.*

An important aspect of Kant which distinguishes his account of autonomy from other accounts, is that a person’s autonomy, being a trait of what it is to be human, is independent of values, contextual reasons and moral attributes which may be externally imposed on any choice or decision to be made. A person’s ability to reason is viewed by Kant not only as the supreme value, but also as the only moral duty, namely to respect autonomy of both self and others by nature of all human beings’ possession of reason.

Kant’s account of autonomy correlates with both negative and positive freedom. Negative freedom means that choices and actions are free from the effects of external factors such as the influence of peers, desires or outcomes. Positive freedom is linked to the idea that a person

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who has autonomy of will has an intrinsic and deep rational commitment to particular principles of conduct which are rationally binding.

The implication of the idea of negative freedom is that the question of ‘what should I do?’ is answered not by looking for outside causal determinants, or even current and anticipated desires, but to be aware of a negative freedom to look within oneself when deciding to accept or reject any of these pressures or influences.\(^{122}\) In the Kantian view, dispositions to act are not necessarily reasons to act; they are considerations for deliberative agents to endorse or reject, upon rational reflection.\(^{123}\) The idea of rational deliberation, which is independent of external reasons such as desire, avoidance of pain and pleasure requires choices to be ‘justifiable to oneself not merely \textit{at the moment}, but over \textit{time} and not merely as one reflects on the \textit{products} of one’s choices but also as one reflects on \textit{the sort of person one makes of oneself} by these choices’.\(^{124}\) Hence, autonomy is not merely the capacity to make a choice, but to make a particular type of choice through a process of ‘rational deliberation.’

The positive view of freedom is imposed on a person on the basis of their status as rational agent.\(^{125}\) Rational agents have an obligation to act in accordance with reasons. This means being independent from outside objects or experience ‘to tell us what our duty is’.\(^{126}\) Kant’s categorical imperative derives from this moral commitment or duty to act in accordance with a positive view of autonomous freedom. Whilst as Hill\(^{127}\) notes, a person may not always live up to this notion of positive freedom, that does not mean that they lack autonomy in the Kantian sense of having the human trait of a rational will.

In a clinical setting, applying this Kantian approach to autonomy involves respect for the patient’s autonomy by a practitioner who also has a well grounded knowledge and sense of what guides his or her own decision-making. It is this idea of self knowledge and self respect that precedes and determines expectations of others. The recognition by the practitioner of themselves as a rational moral agent should be the most significant factor influencing their corresponding recognition and treatment of the patient as equal in terms of their rational moral agency. This requirement of self recognition as a rational agent and self reflection is independent of the values and outcomes that may, in addition, influence the exchange of communication. Respecting

autonomy in the sense discussed by Kant means respecting the person as an equal in terms of ‘the capacity of each person being able to self-critically evaluate and give order and personal integrity to their system of ends’.  

The idea of a patient who is dependent on a health professional’s advice retaining also a distinct autonomous and rational ability to reason through available choices is what is required by the Kantian concept of autonomy. In meeting the requirements of voluntariness of decision-making, the patient would need to be free from any coercion or overbearing influence on their decisions. In addition, according to Kant’s view of autonomy they should be free to make rational decisions from the basis of externally provided information and, more significantly, from the basis of their own internal, impartial and reasoned thought processes.

Applying these interpretations, compliance with the elements that make up informed consent would take on a much broader and reflexive focus than just following the guidelines which list the information to be disclosed. The elements of informed consent which focus only on giving information about risks and benefits, and obtaining consent either verbally or in writing appear to provide only a superficial translation of what is required to honour such a complex ethical ideal. From a Kantian perspective, the clinical information component of informed consent would be recognised as information that is but a component of the patient’s autonomous decision-making choices and involvement in the treatment. Missing from the list of elements of informed consent is the key Kantian notion of rational, self-reflective deliberation. Spriggs suggests the basis of autonomy and the actions required to respect and recognise Kant’s view of autonomy in clinical practice are to be found in the idea of individual freedom to ‘pursue the dictates of a self-legislated ethical system’.  

From this basis, the context and conditions which enable patient voluntariness of decision-making become more important than meeting the more superficial elements of disclosing information and, on a verbal or written level, obtaining agreement or consent.

In the next section I contrast Mill’s ideas of autonomy to those of Kant. I discuss Mill’s ideas about the importance of independence, individuality, liberty and utility as the source of, or reasons for acknowledgement of a person’s autonomy, and contrast those notions with Kant’s notion of reason.

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Mill

John Stuart Mill’s utilitarian framework states that ‘actions are right in proportion as they tend to promote happiness (pleasure and the absence of pain); wrong as they tend to promote the reverse of happiness’. In an important distinction from his predecessor, Bentham, Mill puts a more altruistic slant on the pursuit of pleasure, namely, that one’s actions should aim at the general happiness, regardless of whether this will increase one’s own happiness.

Mill does not specifically refer to the notion of autonomy, but he argues that to be able to pursue our various ends without interference there is a need for both individuality of character and freedom or liberty to choose. This argument links with the notion of autonomy in several respects. The idea of non-interference with an individual’s autonomous action is the antithesis of the competing value of autonomy, paternalism. The idea of liberty and freedom to choose fits with ideas of autonomy, being ‘the capacity of each person to pursue her or his life in an original and spontaneous way as an independent and self determining moral agent.’ The idea of individuality of character also has links with the notions of independence and self determination within autonomy. The famous passage from *On Liberty* demonstrates Mill’s ideas of the importance of non-interference with individuals and the fact that individual autonomy and freedom of will should only be limited if there is likely to be harmful consequences to any other person or persons:

That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forebear because it will be better for him to do so, because it will make him happier, because, in the opinions of others to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreaty him, but not for compelling him, or visiting him with an evil in case he do otherwise. To justify that, the conduct from which it is desired to deter him, must be calculated to produce evil to some one else. The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

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Mill used the ‘utilitarian calculus’ of everyone’s pleasures and pains as the justificatory moral imperative for treating people equally.\(^{137}\) He argued that pleasure and freedom from pain are basic desirable ends.\(^{138}\) Actions and choices are therefore to be judged as ‘right’ or ‘wrong’ in terms of their promotion of happiness. This means that what is important to an individual’s autonomy is not so much whether the person acted from the basis of personal reason (which is required as a moral categorical imperative according to Kant),\(^{139}\) but that their actions represent a freedom to choose what is personally fulfilling or what would maximise their own happiness. Individual autonomy and freedom of will construed in this way should only be limited, as the quote outlines above, if there is likely to be harmful consequences to any other person or persons.

Applying Mill’s ideas that are relevant to autonomy, as an underlying basis for the elements of informed consent in the clinical encounter, necessarily focuses on patients’ freedom to choose and their resultant happiness with their choice and/or the value of the outcome in achieving overall happiness. From this basis, the element of non-coercion or voluntariness would be the most significant.

I contend that Mill’s ideas of freedom of choice could be interpreted in different ways within a clinical setting. For example, at a superficial or technical level, as long as a therapist gives their patient relevant information and then allows them freedom to choose to accept or reject the treatment offered, or alternatives available, then the therapist has respected the patient’s autonomous choice. On a deeper level, Mill’s ideas might also facilitate some enquiry as to what constitutes patients’ happiness from their personal perspective.

What is apparent when Mill’s ideas about autonomy are transposed to a clinical setting is that they are open to a range of different interpretations and, I would argue, are less applicable to notions of autonomy and, more specifically, informed consent, than Kant’s ideas. According to Spriggs the discussion of autonomy by Beauchamp and Childress increasingly relies on Mill’s ideas of freedom of choice over the Kantian notion of rationality and the role of reason.\(^{140}\) As a consequence, their conception of autonomy (in the fifth edition of their book) including how it might underpin informed consent, is a concern about a person’s ability to exercise their


\(^{139}\) Kant, I. (1998), p 52.

\(^{140}\) Spriggs, M. (2005), pp 56-64. Here the author is referring to successive editions of their book, *Principles of Biomedical Ethics*. 
autonomy, rather than a concern with accounting for the meaning of autonomy in a Kantian sense.\textsuperscript{141}

\textsuperscript{141} Beauchamp, T., & Childress, J. (2001), pp 57-104.
Spriggs refers to fundamental differences in the notions of autonomy derived from Kant and Mill. The differences are found in the significance to autonomy of both reason and desires. For Kant, the notion of ethics is based on reason, which determines its own ends, and ‘choice is only free when it is determined by reason alone.’\textsuperscript{142} Moreover, ‘when choice originates in feelings or desires, it is somehow not our choice and therefore not autonomous.’\textsuperscript{143} For Mill, the influence of feelings and desires do not negate an autonomous choice and, in addition, Mill was mostly concerned with civil liberties in a political context whereas Kant was concerned with autonomy as a ‘fundamental moral principle.’\textsuperscript{144} These differences in overall approach or premises have led to both misinterpretations and critiques of the relevance of Kant and Mill in clinical contexts, including their role in providing a moral basis for ideas of autonomy.

\textit{Possible mis-interpretations of Kant and Mill in the clinical context}

Although Mill’s utilitarian ideas identify good with satisfaction of preferences or pleasure, thereby promoting the inherent value in an individual’s autonomous right to freely choose or make a preference, some authors have suggested that utilitarian ideas do not account for the ethical value intrinsically to be found in respect for autonomy. Haworth notes, for example that Mill’s ideas of autonomy do not incorporate an interest in the origin of a person’s pleasure or preference.\textsuperscript{145} Charlesworth suggests that although a consequentialist argument results in a more specific list of likely effects of respecting autonomy, it does not accord an absolute value to autonomy as an ethical ideal.\textsuperscript{146} He suggests that this provides the possibility for different motivations to guide respect for a patient’s autonomy and autonomous preferences. On the one hand respect for a person’s autonomy might be based on the idea of respect for the bearer of the preference and their right to have a preference. On the other hand, it may be based on the nature or outcome of the preference itself.

In this way, Mill’s ideas of freedom of choice and resultant happiness may be misconstrued or at least applied differently in different situations. Where happiness is the ultimate goal, it becomes easy to confuse the patient’s view of happiness with the therapist’s view. For example, there is a

\textsuperscript{142} Spriggs, M. (2005), p 36.
\textsuperscript{143} Spriggs, M. (2005), p 36. Author’s italics.
\textsuperscript{144} Spriggs, M. (2005), p 36.
\textsuperscript{146} Charlesworth, p 209.
recognisable distinction between respecting a person’s autonomous preference on the basis of what is being preferred rather than on the premise that the person has an autonomous right to have their preferences respected. In the clinical context, in some cases the outcome may be indistinguishable. If, for example, a patient presents to a physiotherapist with acute knee pain, treatment expedience and simplicity of the presenting problem and solution may motivate a physiotherapist to disregard the need to consider any difference in the source of or motivation for respecting the patient’s choice. That is, they may not actively consider the person’s autonomous right to have a choice and to have particular reasons for that choice, other than how it relates to an expedient and obvious therapeutic outcome of pain relief. Questions as to whether the therapist is motivated to maximise the patient’s happiness (relief from pain) because the patient has a clear preference for this outcome, or whether the therapist is seeking to relieve the patient’s pain because that is the best therapeutic outcome given the demands of time and the need to fit in the whole of a patient list for the day, may become indistinguishable because of the presumption that what the patient wants is the same as what the therapist wants to achieve. The possibility of separating out the preference for decreasing pain or discomfort from the autonomous nature of the person in having a right to make a preference is often dissolved into what Richards calls the ‘utilitarian aggregate’ or ‘a type of sympathetic benevolence.’

In other words, the utilitarian view of patient autonomy may at the level of practical implementation be collapsed into recognising and working towards a good therapeutic outcome, not just for this patient but as a way of maximising happiness and satisfaction for patients in general. From this basis, although patients are free to make choices, their actual choice and its basis in autonomously formed reasons may be subjugated for the overall happiness of achieving a therapeutic outcome which occurs in consideration of all other patients seeking treatment on the same day or in terms of a presumption that the patient is happy with the same outcome as the therapist’s definition of the best therapeutic outcome.

Kant’s moral philosophy and stance on autonomy has been regarded as problematic not because it might be collapsed into achieving pragmatic or contextual goals but because its’ ‘formalism’ and ‘absolutism’ demands uncompromising standards. According to Richards, the problem with Kant’s view of autonomy which emphasises a person’s individual rational capacity for

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148 Gillon, R. (1986). *Philosophical Medical Ethics*. Chichester, United Kingdom: John Wiley and Sons, p 17. Gillon discusses how Kant’s moral philosophy has been regarded as too austere and does promote obligations of promoting happiness in others.
choice viewed separately from external sources and influences, is that if the person does not explicitly demonstrate skills and propensities towards self reflection and deliberation, their autonomy is at the mercy of being fostered or stunted according to the understanding and moral agency within the person with whom they are dealing. Applying this view directly to the clinical encounter, where the patient attends physiotherapy the therapist could stunt the patient’s autonomy, or at a minimum, fail to promote the patient’s autonomous decision-making, if they failed to recognise the patient’s ability to think rationally and autonomously and instead decided to impose their (clinically-based) reasoning to any patient decisions. The problem in interpreting and applying Kant in a clinical setting seems to relate to the therapist not meeting the moral standards required and ignoring or mis-judging the patient’s capacity to reason, and imposing their own judgement.

Notwithstanding these criticisms and reservations about the relevance and usefulness of the fundamental ethical theories, the discussion so far highlights that trying to apply ideas from Kant and Mill to clinical practice directly is not straightforward and requires further analysis of the concept of autonomy as it might be relevant in a healthcare setting.

The work of Gerald Dworkin\textsuperscript{150} and Robert Young\textsuperscript{151} is useful in providing links from the underlying theories of Kant and Mill. Their discussions look toward a more practical interpretation of the fundamental theories of Kant and Mill.

\textit{Dworkin’s conception of autonomy}

Dworkin argues that a conception of autonomy which insists upon substantive independence, as Kant’s does, is inconsistent with other important societal values.\textsuperscript{152} For example, loyalty, friendship, commitment to a cause and commitment to uphold professional values can all impact on the substantial independence of an individual.\textsuperscript{153} He prefers a conception of autonomy which is a somewhat weaker or diluted version of both Kantian and utilitarian theories of autonomy. He does this initially by identifying what he considers to be the common purpose in such theories. Such common purposes are, in his view, twofold. First there is the desire to ‘treat others as equal

\textsuperscript{150} Dworkin, G. (1988).
\textsuperscript{151} Young, R. (1986).
in certain ways to oneself.\textsuperscript{154} Second, to achieve a measure of moral justification for actions and decisions. He suggests utilitarians achieve equality between one another by treating the interests of each other alike in the calculation of utility. The moral justification is achieved by measuring utility or happiness from the view of an impartial observer. For Kantians the idea that an individual may only act in ways in which he or she is prepared to accept that all others act achieves the criteria of equality and the justification comes from within each individual.\textsuperscript{155}

In his discussion of autonomy, Dworkin highlights the complexities and ambiguities which are inherent in a purely philosophical discussion of an independent and self-determining self, one which he suggests ignores the history, biology and influences of peers, culture and environment. According to Dworkin, tensions and paradoxes are evident in philosophical theories because self determination and notions of correctness and objectivity or reasonable choices are in reality governed by canons of reasoning, norms of conduct and standards of excellence, all of which are acquired by others’ advice, example and teaching.\textsuperscript{156} Because of these external influences, Dworkin believes there are difficulties in ‘true’ self determination, that is, self determination free from external constraints and influences.\textsuperscript{157}

Dworkin proposes as a more practical alternative, autonomy as ‘a capacity that we have a responsibility to exercise and that grounds our notion of having a character’.\textsuperscript{158} He defines autonomy in the following way:

\begin{quote}
Autonomy is a second order capacity to reflect critically upon one’s first order preferences and desires, and the ability either to identify with these or to change them in light of higher-order preferences and values. By exercising such a capacity we define our nature, give meaning and coherence to our lives, and take responsibility for the kind of person we are.\textsuperscript{159}
\end{quote}

Dworkin suggests that if autonomy is really about recognising others as persons, as independent centres of consciousness, then there is a requirement to give weight to the way they define and value the world in deciding their own actions.

Dworkin’s theory looks to elements of both Kant and Mill. He shifts Kant’s metaphysical view of autonomous decision-making in a more practical and recognisable direction to the idea of

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individual capacity which includes critical reflection between higher capacities and lower desires. Although Dworkin suggests that ‘autonomy is a richer notion than liberty,’ he nevertheless recognises that autonomy may be regarded as having instrumental value:

On instrumental grounds, being able to shape one’s own choices and values makes it more likely that one’s life will be satisfying than if others even benevolent others do the shaping.

Dworkin claims that this liberal argument, one which recognises the importance of choosing among preferences as a source of satisfaction to individuals should not be discounted in any discussion of the value of autonomy.

Unlike the writings of Kant and Mill, Dworkin specifically discusses his theory of autonomy as it might relate to the healthcare context. He suggests that the special role that autonomy plays in healthcare, and the major role that it plays in explaining the doctrine of informed consent, is related to the embodied nature of people. That is, ‘the care of our bodies is linked with our identities as persons’ and whatever ‘goals or values we have are tied up with the fate of our bodies.’ By this Dworkin is suggesting that as ‘one’s body is irreplaceable and inescapable’ and because one’s body ‘is me’ then it follows that ‘failure to respect my wishes concerning my body is a particularly insulting denial of autonomy.’

Dworkin’s theory neatly encapsulates the interaction between patient and therapist in the treatment encounter. The autonomous patient is given the opportunity to exercise capacity and to take responsibility. His view of autonomy and autonomous choice encompasses recognition and active encouragement of a patient's capacities, views and individual character. If Dworkin’s account of autonomy was regarded as the supporting theoretical framework for informed consent in the clinical setting the focus of the recognised elements (table 2-1) would require reorientation, a change of both emphasis and order. For Dworkin, obtaining a patient’s informed consent as a method of respecting their autonomy would first involve the therapist seeking information from the patient. That is, rather than the ‘duty’ based approach which may be seen to commence with the giving of information to the patient.

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Obtaining the consent of the patient without knowing about the person, their views, identity and character, would contravene the underlying notion of respect for the person’s autonomy. In the clinical physiotherapeutic context, such knowledge of the patient may typically be limited to what is relevant to the manual treatment of low back pain or shoulder stiffness. However, this level of knowledge of the patient would not satisfy the Dworkin criteria. If the underlying assumption is that a person’s beliefs, values and identity are embodied within their physical sense of self, gaining their consent to a treatment that affects their physical self and which is based on respect for their autonomy must encompass curiosity about and exchange between therapist and patient concerning the internal motivation, character and beliefs of the patient. Based on Dworkin’s view of autonomy the element of information disclosure would be a much richer notion. It would be preceded and guided by knowledge of the patients’ values, character and preferences. It would be given individually and tailored to the patient rather than given based on the Hippocratically oriented therapists’ view of what would be in the best interests of the patient. Taking Dworkin’s view, it is to miss the whole point of the interaction and to ignore the patient as an autonomous person if information is given based only on the physiotherapist’s personal or professional evidence base.

If autonomy according to Dworkin means a capacity to reflect on first order preferences by higher order preferences,165 I suggest that with reference to the accepted elements of informed consent, the element of voluntariness would take on a richer meaning. Ensuring voluntariness would involve attending to the context and conditions of the communication more broadly so that patients were afforded opportunities to reflect on the meaning and consequences of any information and choices, rather just be given information and freedom to make choices. The ground rules of the communication should establish a sense of equality, interest and mutual respect between the therapist and the patient.

For example, a patient presenting to physiotherapy with low back pain may have a (first order) preference for passive treatment such as massage and application of electrotherapy for relief of their pain, rather than more active treatment requiring ongoing exercise and postural adjustment. The therapist could respond by offering a choice for either massage or exercises or a combination of the two. In so doing, the therapist has provided sufficient information to comply with formal

165 Dworkin, G. (1988), p 108. By higher order preferences, Dworkin is referring to the capacity to reflect on one’s motivational structure and to make changes to that structure, or to critically reflect on initial preferences and desires, and to be able to either identify with these desires or change them.
requirements of information disclosure and informed consent. However, using ground rules of communication that flow from Dworkin’s ideas of autonomy the therapist would tailor information and communication to enable the patient to reflect and think about the nature and likely outcomes of both active (favourable long term results) and passive treatments (short term pain relief), rather than just giving them freedom of choice. Importantly, it is the recognition by the therapist of capacities for autonomous thinking that constitutes respect for their patient’s autonomy. If the patient is given information which acknowledges and presumes that they have capacities for critical reflection the patient may reflect on those initial preferences and decide to opt for more active involvement.

Dworkin incorporates aspects of a utilitarian view by linking the promotion and support of a person’s capacities for self determination to the likely outcome if such capacities were promoted. According to Dworkin respect for autonomy means respect for a person’s views, intrinsic identity and character, and provision of opportunities for a person’s capacities of reflection to grow and develop. By adopting these approaches he is able to give an account of autonomy that has roots in the metaphysical, deontological, and utilitarian theories, but is also grounded in attitudinal or behavioural features of persons.

Approaching the clinical encounter informed by and in accordance with Dworkin has the consequence that the patient’s consent is more than an agreement to proceed with the therapist’s suggestions. It is a meaningful consent arrived at following, and in consequence of, considerations and reflection by the patient of their views of the proposed management of their problem informed by the therapists’ expertise as to treatment benefits, risks and alternatives.

Dworkin’s notion of autonomy emphasises the ideas of reflection and thinking as important elements. He incorporates Kant’s ideas about the importance of self directed reasoning to inform autonomous decisions, but uses a framework of reflection, rather than rationality as the basis of autonomous self determination. According to Dworkin’s ideas, to respect a person’s autonomy must mean that one has to hold in some esteem, or regard as vital to the process, the thoughts and capacities for thought of that person. In practical terms, as discussed above, this notion means that the actual choice of the person is less important than the conditions that led to the choice.

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Young’s account of personal autonomy

Where Dworkin suggests that autonomous actions or choices should be made on the basis of reflection of a primary desire with a higher order desire, Young suggests that reflection should be broader and decisions about actions should be situated according to an overall direction of preferences. The key difference between Young and Dworkin concerns the scope of reflection. In his book, *Personal Autonomy, Beyond Negative and Positive Liberty*, Young proposes a practical interpretation of both Mill’s utilitarian ideas of freedom of choice and Kant’s use of reason. He suggests that the fundamental idea in autonomy is that of ‘authoring one’s own world without being subject to the will of others’. In recognition of what Dworkin regards as complexity and ambiguity within broad philosophical theories, Young suggests that an inclusive characterisation of autonomy is critical to ‘do justice to its various nuances’ as an ideal character trait. In his view it should include a middle position on the value and meaning of reason to autonomy and it must not be so individualistic that it neglects the reality of the often collaborative needs of people. It should therefore not rely on an absolutist view of freedom or reason.

For example, with reference to Kant’s ideas of reason and rationality Young suggests that a requirement of rationality which demands a continuous and conscious evaluation and re-evaluation of actions and plans is too stringent a requirement and therefore ‘reason should neither be construed too imperialistically nor made to appear like a task master (demanding of us constant self evaluation).’

His middle ground consists of two positive requirements to link autonomy to reason. The first is that autonomy brings coherence into the relationship between a person’s general purposes and his or her particular actions. Second, that it ‘equips a person to assess critically the advice tendered by others’. The second point is particularly important in a healthcare context where advice and information given by a health practitioner to a patient is a consistent feature. Young concludes that without being arrogantly self reliant autonomous persons should not ‘accept what they are told without any reason, or with too little reason to regard the testimony as reliable’.

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167 Young, R. (1986).
The content of individual self determination, according to Young, should incorporate how an individual is able to understand and make use of their freedom. For example, he suggests that freedom from the authority of others does not always work because an insufficiency of resources (such as poverty, past experiences, level of education) can still limit the option of an individual or state to exercise autonomous options.\textsuperscript{173} It follows that whilst freedom from the authority of others is a necessary condition, it is not the only condition. As Young notes, freedom of choice may result in freedom expressed by ‘mindless mimicking of other tastes, opinions, goals and values’.\textsuperscript{174} The freedom to choose should contain more. The choice itself should express the person’s own aspirations and preferences.

Young prefers a conception of autonomy which does not rely on the negative and narrow notion of freedom from interference or governance by others, but rather is measured according to the more positive and broader based ability to direct one’s own life and life plans.\textsuperscript{175} Importantly, this more positive focus is also able to distinguish between an occurrent sense of autonomous ability, where people choose particular actions within a given situation, compared to the more comprehensive and richer claim of dispositional autonomy, concerning the overall direction of a person’s life.\textsuperscript{176}

Young defines a person’s dispositional self-directedness to be an ability to order their life according to a plan or conception which fully expresses their own will. From this perspective, self direction is an expression of the rational nature of persons and reason is linked with autonomy as the most valuable means of controlling one’s surroundings. He suggests that reason can be linked to autonomy because of its influence on the capacity to discern truths and lies, to make deductions and inferences, to formulate hypotheses, to empathise and to appreciate the central features of a situation. Young discusses reason in terms of its value in allowing a person to ‘author their own world.’ This is not the same as Kant’s view of reason as the central feature of moral action.

Young does not relate his account of personal autonomy specifically to the clinical setting. However I suggest the difference between and significance of occurrent and dispositional senses of autonomy are potentially significant in a clinical setting, particularly in relation to the scope

\textsuperscript{173} Young, R. (1986), p 12.
\textsuperscript{174} Young, R. (1986), p 8.
\textsuperscript{175} Young, R. (1986), p 8.
\textsuperscript{176} Young, R. (1986), p 8.
and purpose of the information. For example, if the patient in a physiotherapy setting is given the option of taping his or her ankle in order to return more quickly to their sporting endeavours, or, on the other hand missing a game to facilitate more long term healing, the patient may make a short term (occurrent) decision to take the former option. In contrast, a decision which is dispositional in the sense that it is based on a conception of the overall course of the player’s life plans, may take into account longer term effects of possible joint damage and re-injury in the future. If a therapist had an understanding of the need to respect their patients’ occurrent and dispositional autonomy, and recognised value in promoting and enhancing a patients’ self awareness and ability to distinguish between these temporal senses of autonomy, the therapist would correspondingly recognise the need to provide information about the long term effects of possible damage to the joint if the patient plays with partial healing. In other words, the therapist would be obliged to provide an opportunity for the patient to distinguish between short term consequences and how the decision may affect the overall direction of that person’s life.

In the same way that the broader context of the communication, according to Dworkin, assumed much greater significance in terms of enabling a person’s capacity to reflect between higher capacities and lower order desires, Young’s ideas similarly enrich the content and context of the interaction. According to Young the communicative interaction, if it is to be based on respect for another’s autonomy, should encompass an acknowledgement of the patient’s dispositional and occurrent thoughts and plans. The more specific element of consent comes only after these broader conditions have been met.

At the next level (layer five) of the iceberg I highlight the account of autonomy by Beauchamp and Childress in their discussion of the principles of biomedical ethics. This is the most practical and clinically oriented account of autonomy. It is closest to the above surface area of the iceberg because it focuses on the value and meaning of autonomy specifically as it relates to the clinical context and other ethical principles.

**Beauchamp and Childress respect for autonomy**

Beauchamp and Childress are the leading proponents of a ‘principles’ approach to biomedical ethical thinking. Their account of the meaning and application of the four principles

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(autonomy, non-maleficence, beneficence and justice) has influenced biomedical ethics to such an extent, that it is ‘thriving throughout the biomedical world’\textsuperscript{179} However they are not without their critics.

Gert et al. argue that the reliance on \textit{prima facie} principles (principlism) espoused by Beauchamp and Childress functions more as a checklist for the purposes of considering issues pertinent to a biomedical moral issue, rather than a theory of autonomy espoused by moral reasoning.\textsuperscript{180} According to these authors, Beauchamp and Childress do not embody an articulated, established and unified moral system capable of providing useful guidance.\textsuperscript{181} Those authors conclude that by its failure to provide genuine action guides and by its ‘eclectic and unsystematic account of morality’ principlism in fact obscures and confuses moral reasoning.\textsuperscript{182} In particular, the two elements of confusion which stem from the principle of autonomy are the lack of clarity as to what counts as autonomous choices applied as \textit{prima facie} principles and a blurring of the basic moral distinction between moral rules and moral ideals.\textsuperscript{183} Spriggs makes a similar argument in her book \textit{Autonomy and patients’ decisions}.\textsuperscript{184} She provides an account of the changes in Beauchamp and Childress’ chapter on autonomy in successive editions of the Principles of Biomedical Ethics. Importantly Spriggs notes a general shift, after the second edition, towards de-emphasising the philosophical ideas of autonomy from both Kant and Mill, indicating ‘less concern with the history or origins of the idea of autonomy.’\textsuperscript{185} In my review of autonomy according to Beauchamp and Childress, I rely on the fifth edition.

Whilst Dworkin and Young provide a more conceptual and analytical approach to the meaning of autonomy to underpin the clinical encounter, Beauchamp and Childress are positioned closer to the surface elements (table 2-1) of informed consent with their emphasis upon what a practitioner ought to do, rather than on a reflective perspective of what respect for autonomy means in clinical practice.

In defining autonomy, one of their main concerns is to reduce what they regard as an aspirational account of autonomy to an achievable account of autonomy, one which is within reach of normal

\textsuperscript{184} Spriggs, M. (2005), p 64.
choosers. Their focus shifts from what thinking processes ought to ideally occur, to what choices should be actually recognised as autonomous choices. For example, they reject Dworkin’s account of autonomy on the basis that the ideal of reflection between higher and lower order desires is out of the reach of the ordinary chooser. Instead, they seek to ground autonomy in ‘non ideal moral requirements’ of actions of normal choosers who act intentionally, with understanding and without controlling influences that determine their action. In so doing they shift the emphasis from what they regard as the philosophically-based understanding of an ideal, practically unobtainable, or a-social autonomy to a more practical understanding by emphasising autonomous choice which is within reach of ‘normal choosers’.

They achieve this by introducing the less exacting requirement of substantiality in relation to the required level of understanding and the degree of external influence which potentially impacts on a normal chooser’s autonomous decision-making. Additionally, they place the principle of autonomy on a level playing field with other foundational moral principles by recognising autonomy as a prima facie moral principle, that is, always binding unless it conflicts with obligations expressed in another equally valid principle.

Beauchamp and Childress adhere to the list of elements of informed consent outlined earlier in the chapter (table 2-1), treating those elements as elements of freedom of action or non-interference with action. However, in their writings, whilst they assume an underlying concept of patient autonomy, they do not define or provide an account of how its meaning influences its implementation. I contend that without a conscious understanding of its meaning, particularly from the philosophical base of Dworkin and Young and their interpretation of Kant and Mill, a health professional may comply with the obligation to give information and to refrain from overtly influencing a patient, all without respecting a patient’s autonomy from the perspective of its deeper ethical meaning. For example, a physiotherapist in choosing between two treatments to offer a patient, could weigh up the risks and benefits of the treatment in accordance with her own clinical abilities, experience and/or objective scientific evidence and then offer this pre-formulated information to the patient on the basis of the therapists’ personal and professional clinical reasoning process. Respect for the patient’s autonomous choice of treatment alternatives in that context is limited to choosing this practitioner and the choices he or she makes as a

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professional. If a deeper ethical meaning of autonomy guided the implementation of the elements of informed consent, such as the recognition of patients’ capacities to reflect and enquiries as to their short and long term desires, then the elements of informed consent would include an overriding requirement to enhance the thinking, reflecting and reasoning abilities of each patient. This would mean making some enquiry or establishing some dialogue with the patient which engaged with and included the patient’s views.

Whilst acknowledging that informed consent should be based on the moral ideal of autonomous authorisation, the concern of Beauchamp and Childress is to chart an attainable course. That is, a course between, on the one hand, the demands of a ‘rigorous autonomy–based model’ and on the other hand, one that is mindful of the effects of such policies of informed consent on:

- efficiency and effectiveness in delivering healthcare and advancing science, and the effect of consent requirements on the welfare of patients.  

These qualifying remarks about ethical stringency on the one hand and practical implementation on the other lead Beauchamp and Childress to the formulation of the constituent elements of informed consent (table 2-1), the point at which this chapter began.

When I applied Kant’s deontological theory of autonomy to the clinical practice context, I demonstrated a requirement for ideals of rational deliberation, a view of autonomous action as part of a moral imperative, and little regard for external influences. I argue that Beauchamp and Childress run into similar problems but at the other end of the spectrum. Their interpretation relies on positioning the principle of autonomy within the demands of the particular clinical context and other moral principles. Their approach has the effect of leaving gaps, which may be filled by an individual interpretation of the meaning and value of autonomy, based on externally based clinically justifiable professional practice goals and good intentions.

These different ends of a spectrum or different emphases given to theory and practice validate my placement of the various layers of the iceberg framework by suggesting that unless the ethical meaning of autonomy is supported by a logical and detailed framework such as those espoused by Kant and Mill and ethical theories of autonomy described by Dworkin and Young, then I contend there is a danger that the deeper aspects of the iceberg will not guide and give content to

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the more superficial elements. The consequences are that the elements of informed consent may be applied at a superficial level and only in particular circumstances.

**Summary of section one and section two**

In this chapter I began by outlining layer two of the iceberg framework of informed consent, the accepted elements of informed consent. I examined the genesis and implementation of the elements in law, medical practice and empirical research. The main findings of this review were that the law has applied a protective rights based gloss over the elements of informed consent, which encourages a valid but minimalist approach to the practical implementation of the elements. I demonstrated that informed consent and underlying ideals of patient autonomy were not a traditional component of medical practice. The reactions of the medical profession to its imposition by law, and by bodies regulating the conduct of research, have ranged from indignation and resistance to a degree of acceptance evidenced by the development of professional guidelines stipulating the need for compliance with informed consent as a legal and ethical obligation. The guidelines written to guide its implementation in clinical practice have largely focused on two elements: what information should be disclosed and what type of consent from a patient is necessary to achieve an acceptable level of legal compliance. Empirical studies of the practice of informed consent have focused on various aspects of the elements of consent and they have measured both compliance with their implementation and how practitioners understand the different elements. The studies have not examined the ethical meaning of informed consent, but rather have sought to examine and measure its implementation.

In the second half of the chapter I moved to the base of the iceberg framework and examined theories of autonomy and at the same time discussed how this theoretical knowledge might translate into or alter the implementation of the above surface elements of informed consent in practice. The discussion of Kant’s theories highlighted the importance of each person’s inherent ability to reason and reflect as a basis of action. The consequences of this in practice means that respect for autonomy requires self knowledge, self reflection and reasoning which (grounded in metaphysical concepts) are able to withstand or rise above the influence of external forces. According to Kant, autonomous action requires both freedom from causal conditions and freedom to act according to a categorical moral duty. Mill on the other hand defines autonomy according to its value in maximising happiness and emphasises a person’s individual right to be free from interference in attaining happiness or pleasure. Respecting autonomy according to this
consequentialist theory requires a focus on freedom of action to pursue individually-based optimal outcomes.

Using these theories as a basis, I then discussed theoretical accounts of autonomy. Dworkin took Kant’s theme of self knowledge and reasoning to a more practical and, to some extent, measurable level using psychological descriptions of self reflective capacities. Dworkin attempts to ground Kant’s metaphysical views of the categorical imperative to act according to reason, to act according to a justifiable relationship between first and second order desires. Dworkin is thus starting to bridge the divide between philosophical theories and idealist duties, and the impact of social context which potentially affects a person’s desires.

Young incorporates the negative notion of freedom by recognising that a person should be free from undue influence when making decisions. He goes further however in endorsing a positive view of freedom which is based on a positive and consistent relationship between a person’s occurrent or immediate ability to act, with their dispositional ability to control the overall direction of their life. Here Young honours the philosophical underpinnings of autonomy whilst incorporating a more realistic view of the impact of society, peers and other external causal conditions on the short and long term goals of a person and on the fundamental ideal of autonomy being the ability to author one’s own life plans.

Finally, the account of autonomy given by Beauchamp and Childress demonstrated a leap into the world of external causal conditions. For Beauchamp and Childress, the principle of autonomy is situated within the demands of other prima facie ethical principles and it must also be able to relate to the requirements of health care practice. The philosophical moorings of reason, self reflection, individual capacities and the relationship between first and second order desires are no longer features in this account of autonomy. I argue that the accounts of autonomy discussed by Dworkin and Young make the tensions, ambiguities and difficulties between philosophical theory and the context of clinical practice apparent and they attempt to find middle ground by giving content to the concept of autonomy as a way of enhancing its application in different contexts. Beauchamp and Childress, instead, aim at simplicity and clarity of behavioural guidelines to suit the clinical context.
Conclusion and key points

The discussion in this chapter has highlighted differences in focus between philosophical concepts and theories that explain what it means to respect autonomy and a list of behavioural duties that arise from these deeper concepts but have been pruned to fit and meet the requirements of the clinical environment in much the same way as an iceberg is different in shape and density above and below the surface. As Faden and Beauchamp state, the transformation of a set of elements into a meaningful definition of informed consent ‘raises as many problems and confusions as it offers insights.’ 192

The review of both discussion about and interpretation of informed consent in the literature and underlying theories of autonomy have demonstrated the original basis and ethical meaning of autonomy is strongly aligned with features, traits and conditions necessary for self determination and autonomous action for an individual person. I contend the specification of that meaning into elements of informed consent has resulted in superficially honouring such meaning in terms of obligations to act. The effect of specifying a moral ideal into a moral rule considerably narrows the scope of the behaviour. 193 In other words, where the legal and professional literature have focussed on information disclosure by a health professional to a patient as a significant component of informed consent, the moral theories about autonomy as they underpin informed consent imply a different and broader set of criteria as important to consider and acknowledge. Those criteria include capacities and opportunities for reflection, freedom of choice, critical awareness of one’s own and one’s patients’ values, desires and character.

Importantly, in this chapter I have demonstrated that the elements of informed consent do not adequately describe or delineate the ethical meaning of autonomy. On the basis of this review my claim is that if the elements of informed consent were more explicitly linked or enriched with aspects of the ethical meaning of autonomy, the emphasis for the process of informed consent would shift from what to do when obtaining informed consent to how to think and what to think when obtaining a patient’s informed consent.

My main contention resulting from the literature review in this chapter is to label informed consent, informed by ethical theory, to be ‘ethically enriched’ informed consent. This notion of informed consent, one that is cognisant of its constituent elements and its underlying ethical

theory, will be used as my gold standard in reviewing other literature, both medical and physiotherapy in the following two chapters.
CHAPTER 3: Clinical models of informed consent – Linking ethical theory to clinical practice

Introduction and aims

In the previous chapter I defined informed consent by reference to an ‘iceberg framework’ of enquiry. Within that framework I defined the recognised and established elements of informed consent as visible (above the surface) and prescriptive guides to its implementation in clinical practice. I explicated the ethical theories of autonomy as providing underlying support to the obligations of obtaining informed consent in terms of ethical values and meaning.

Using the iceberg framework I was able to demonstrate differences in focus between the elements that make up the process of informed consent and the ethical theories of autonomy that underpin this clinical and ethical obligation. Further, I demonstrated that the elements of informed consent have been framed as rules or clinical guidelines and legal obligations. That is, they prescribe particular actions which should be followed by health practitioners in order to fulfil obligations to obtain patients’ informed consent to treatment. In contrast, the ethical theories about autonomy have focused on explaining the meaning of autonomy from the perspective of its universal moral value and from its specific value and role in underpinning informed consent in a clinical context.

Importantly, from my discussion of the elements of informed consent (layer two) and the theories of autonomy (layers five to seven) within the iceberg framework, I developed a notion of ‘ethically enriched’ informed consent. This idea of informed consent draws from the established list of elements of informed consent, but also explicitly includes ideas about autonomy which promote the importance of critical self awareness, and capacities for reasoning and reflection.

In this chapter I review the bioethical literature which has focussed on integrating the ethical theory of autonomy into the clinical process of obtaining a patient’s informed consent to treatment. In particular I review and analyse five models of informed consent which have been developed in the medical literature to bridge the ethical and legal theory-practice divide. The review is directed by two main avenues of enquiry.
The first concerns the way the models incorporate ethical theories of autonomy. That is, how much and what aspects of ethical theories have been used to guide the development of the models of informed consent. Here I refer to my notion of ‘ethically enriched’ informed consent as an analytic framework to guide the review of the models. Models which more closely reflect an ethically enriched process of informed consent emphasise the importance of what to think about more that what should be said or done. That is, they are more attuned to processes of reflection about the meaning and value of autonomy to guide actions, than with the interpretation of autonomy into specific communicative actions.

The second avenue of enquiry concerns the applicability of the models to the clinical physiotherapy context. Specifically, whether they fit that particular context and how their focus might change the practical process of informed consent within that context. I achieve this examination by applying the models of practice to a hypothetical clinical scenario. As a result I identify different features of informed consent which emerge when the models are applied to a hypothetical clinical context.

By the end of this chapter, I will have explicated five key models of informed consent, how they draw from ethical theories of autonomy and how their implementation (in a hypothetical sense) in clinical practice results in different features of the process of informed consent. These features will assist the empirical examination of informed consent within clinical communication discussed in chapters six to eight. The discussion of the models in this chapter demonstrates that all the models are applicable in clinical physiotherapy practice. However I will argue that the ‘conversation’ model of informed consent proposed by Katz1 best represents the ideal of ‘ethically enriched’ informed consent and most profoundly changes the focus and content of clinical communication.

Prior to commencing the review of the models of practice, I begin by briefly reviewing Emanuel and Emanuel’s2 paper on four models of the physician/patient relationship and the role of patient decision-making within this relationship. These authors provide an overarching framework of the nature of the doctor/patient relationship. Although their discussion is not focused on informed consent as a specific process, the models and underlying assumptions about the role of autonomy, patients’ values and doctors’

1 Katz, J. (2002).
obligations are reflected to varying degrees as implicit assumptions and overt justifications within the more specific or targeted models of informed consent which are later discussed.

**Background: Emanuel and Emanuel – four models of clinical relationships**

Emanuel and Emanuel’s aim in presenting their four conceptual models of the physician/patient relationship is to provide a framework for reflection about the ideals and nature of the doctor/patient relationship, and its effect on the patient’s role in medical decision-making. Their four models draw on different understandings of the goals of the doctor/patient interaction, the doctor’s obligations, the role of the patient’s values and the underlying conception of patient autonomy. The four models and these underlying assumptions are summarised in Table 3-1.

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3 Emanuel, E., & Emanuel, L. (1992), p 2221
Table 3-1. Models of clinical relationships.\(^4\)

<table>
<thead>
<tr>
<th>Models</th>
<th>Assumptions about patient values</th>
<th>Doctor’s obligations and role</th>
<th>The conception of Autonomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Paternalistic</td>
<td>Patients have <strong>objective values</strong> which are shared with the doctor.</td>
<td><strong>In their role as their patients’ guardian</strong>, doctors are obliged to act in the best interests of their patients, independent of patient’s current preferences.</td>
<td>For patients, autonomy comprises agreement with objective medical values.</td>
</tr>
<tr>
<td>2. Informative</td>
<td>Patients know <strong>their own values</strong> which are defined and fixed or stable.</td>
<td><strong>In their role as the competent and technical expert</strong>, doctors provide factual information to their patients and implement the patient’s selection.</td>
<td>For patients, autonomy comprises choice between types of medical care.</td>
</tr>
<tr>
<td>3. Interpretive</td>
<td>Patients may have <strong>conflicting or not fully formed values</strong> that may require elucidation.</td>
<td><strong>In their role as patient advisor or counsellor</strong>, doctors provide both factual information and they help to interpret relevant patient values.</td>
<td>For patients, autonomy comprises <strong>self-understanding</strong> relevant to medical care.</td>
</tr>
<tr>
<td>4. Deliberative</td>
<td>Patients’ <strong>values are open to development</strong>.</td>
<td><strong>In their role as their patients’ teacher or friend</strong>, doctors provide factual medical information and the values underlying medical choices.</td>
<td>For patients, autonomy comprises moral self development as it is relevant to medical care.</td>
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In the ‘paternalistic model’, the objective of physician/patient interaction is to ensure that the patient receives interventions based on the promotion of their health and wellbeing. The responsibility for the most appropriate intervention is determined according to who has

\(^4\) Adapted from, Emanuel, E. and Emanuel, L. (1992), p2222.
knowledge of biomedical health outcomes. The underlying assumption is that both the doctor and patient share the same health care objectives. Within this framework, autonomy is defined as:

‘patient assent, either at the time or later, to the physician’s determinations of what is best’\(^5\)

In the event that there is any tension between a patient’s autonomy or choice and the doctor’s determination of what would be the best course of action for an outcome related to health, ‘the paternalistic physician’s main emphasis is toward the latter’.\(^6\) The conception of autonomy in this model is a very thin one, when compared to the ideas of autonomy discussed in chapter two which encompass a capacity for reflection, ability to reason and freedom from constraint.

In the ‘informative model’, the objective of the physician/patient interaction is for the physician to provide the patient with all relevant information enabling the patient to make a treatment decision. In this model, more information is given to the patient on the assumption that facts about a patient’s health are the means by which they may make health care decisions and exercise a measure of control in the treatment encounter. Facts about an illness or treatment are separated from any associated patient or doctor-held values. The facts given, according to this model, include:\(^7\)

\[(information about)…his or her disease state, the nature of possible diagnostic and therapeutic interventions, the nature and probability of risks and benefits associated with the interventions, and any uncertainties of knowledge.\]

This list of information is similar to the information required to comply with the information disclosure element of informed consent discussed in table 2-1, chapter two. The authors’ suggest that the process of informing patients according to this model reflects a conception of patient autonomy which is concerned with ‘patient control over medical decision-making’\(^8\).

The ‘interpretive model’ is similar to the informative model in that the physician provides the patient with information on the nature of the condition and the risks and benefits of possible interventions. It differs from the informative model in that it also aims to promote

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\(^6\) Emanuel, E., & Emanuel, L. (1992), p 2221.
\(^7\) Emanuel, E., & Emanuel, L. (1992), p 2221.
\(^8\) Emanuel, E., & Emanuel, L. (1992), p 2221.
a level of understanding for the patient to assist them in elucidating and articulating their own values in relation to the treatments offered. In this model, the role of the doctor is much broader. Starting from an assumption that patients’ values are integral to healthcare and, more significantly, that they may differ from those of the doctor, the role of the doctor is ‘to work with the patient to reconstruct the patient’s goals, aspirations, commitments and character’.  

The interpretive model encompasses the provision of technical knowledge (informative model) but distances itself from making decisions on behalf of the patient (paternalistic model) and the role of the doctor includes acting as a counsellor and advisor.

The conception of autonomy in the interpretive model reflects both Dworkin’s and Young’s view of autonomy. According to the aims and assumptions of the interpretative model, autonomy concerns self knowledge and Emanuel and Emanuel suggest that ‘the patient comes to know through self understanding, who he or she is and how various medical options bear on his or her identity.’

The fourth model is the ‘deliberative model’. Like the interpretive model, it is not just concerned with the provision of information about the clinical situation. It is also concerned with providing information about values inherent in health related options. The role of the doctor in this model is further expanded. It involves the doctor not just making space for the patient’s broader concerns related to values and health beliefs, but also engaging in deliberation about ‘what kind of health related values the patient could and ultimately should pursue’. In this model, the conception of patient autonomy is moral self development, defined as follows:

the patient is empowered not simply to follow unexamined preferences or examined values, but to consider, through dialogue, alternative health related values, their worthiness, and their implications for treatment.

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Within this conception of autonomy, both Kant’s ideas of inherent dignity and reasoning ability associated with autonomous decision-making and Dworkin’s reflection on first order desires are recognisable. The underlying assumption in the deliberative model is that both the patient and the doctor have equal abilities to engage in deliberation and reasoning associated with health related decisions.

In chapter two I contended that implementation of the visible elements of informed consent would be enriched by an understanding of the underlying ethical theory. Whilst Emanuel and Emanuel do not explicitly draw upon specific theories of autonomy, their exposition of the conception of autonomy particularly in the ‘interpretive’ and ‘deliberative’ models of patient/doctor relationships, demonstrates that a deeper and more reflective understanding of its meaning within clinical communication changes the role of the doctor and the very basis of the patient/doctor relationship.

In the next section I examine five models of informed consent developed to link ethical theories of autonomy to the process of informed consent in medical practice. Both Emanuel and Emanuel’s models of the doctor/patient relationship (including their assumptions about the doctor’s role, the value of autonomy and the nature of the therapeutic relationship), and the iceberg framework (emphasising different levels of ethical theory contribution and practical actions), will be used as an analytic backdrop to the discussion of the models of practice.

Whilst representing a new focus of review, the purpose of my review of the models is to examine the impact that ethical theories of autonomy have on the process of informed consent in clinical practice, as described by models and as applied in a hypothetical case scenario.

Models of informed consent.

The approach in the bioethical literature for medical practitioners has been to develop a range of models which link to varying degrees the underlying ethical principle of autonomy to the practice of obtaining informed consent. Although these five models are significant contributions to the bio-ethical literature about informed consent, they have not been analysed in the literature as a group with reference to their explicit connections to the underlying theory of autonomy. Some of the models are similar to the action oriented and
compliance focus of the physiotherapy literature. Others, most notably Katz, have focussed on the need to reflect and think about the meaning of patient autonomy as a way of informing appropriate actions and attitudes within the clinical relationship.

I have categorised and diagrammatically represented the models of practice pertaining to information disclosure and informed consent along an action/reflection spectrum (figure 3-1).

**Figure 3-1: Models of informed consent: Action/reflection spectrum**

Models which are positioned towards the ‘practical action’ end of the spectrum attempt to reduce the complexity of values, meanings and influences behind the idea of informed consent to a set of communication actions that are identifiable and practically useful. Such models are essentially prescriptive. They describe what to say or what should be said. They specify the value of informed consent in relation to the goals of the clinical encounter.

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They simplify the types of communicative actions and give direction as to the content of the communication required to satisfy legal and ethical requirements of informed consent.\textsuperscript{16}

The three models at the action end of the spectrum each attempt to operationalise the requirements and obligations of informed consent. I argue that in their emphasis on how to implement informed consent within clinical practice they might be seen to neglect the underlying ethical ideals and meaning of autonomy. Their underlying assumptions are grounded in the context and realities of clinical practice and the meaning of the elements of informed consent are explicated in this context. They do not question the role of the doctor or the relative roles of medical facts and patient values.

Towards the reflective end of the spectrum are two models that have greater explanatory power. They provide background information about theoretical assumptions that contribute to the idea or the meaning of the practical phenomenon of obtaining informed consent in clinical practice.\textsuperscript{17} They do not immediately translate to a practical communication action nor do they provide a prescriptive code of conduct against which behaviour can be procedurally evaluated. Instead, they paint a conceptual picture of what attitudes and reflection underpin the communicative action of informed consent. I contend their approach more explicitly incorporates underlying ethical theories of autonomy.

In the following sections, I discuss each of the models along the spectrum. I discuss how they have incorporated ethical theories of autonomy and in so doing I justify why I have situated them as either predominantly oriented to action or reflection.

\textit{An event model of informed consent (Wear)}

Although Wear’s book \textit{Informed Consent Patient Autonomy and Clinical Beneficence within Health Care} was written from a background encompassing both philosophy and clinical practice,\textsuperscript{18} the stated aim of the book demonstrates a pragmatic emphasis on the clinical

\textsuperscript{18} Wear, S. (1998). At the time of writing, Wear was Clinical Associate Professor in the Departments of Medicine, Obstetrics and Gynaecology, and Philosophy, and Co-Director of the Centre for Clinical Ethics and Humanities in Healthcare, State University of New York.
context ‘to fashion a comprehensive sense of informed consent as an effective, efficient, and needed tool for medical management’.\textsuperscript{19}

From this basis, Wear is clearly concerned with a practical interpretation of the obligation to obtain informed consent. I have placed Wear at the action end of the spectrum, some distance from the reflective end for three main reasons. First, Wear gives primacy to what he terms as an event model of informed consent, in which a patient’s authorisation to treatment does not occur randomly, or as an embedded component in the clinical interaction. Instead, it is given a specific and formal place, usually at the point where treatment is going to be initiated or modified. Within the event model, the requirement for informed consent is a specific one, related to the goals of the clinical encounter. Wear relates the obligation to obtain informed consent to specific actions which can be achieved in clinical practice. He claims, for example, that the event model is more readily documented and standardised both as a generic model and with reference to particular interventions.\textsuperscript{20}

Second, Wear situates informed consent within the norms and objectives of clinical encounters. He seeks to operationalise informed consent in a way that helps the doctor fit the requirement into the doctor’s usual practices.

Third, Wear is concerned with how the process of informed consent fits in with aims and therapeutic activities of the treatment encounter. The core function of informed consent according to Wear lies in the notion of patients actually participating, in an active sense, in medical decision-making.\textsuperscript{21} From this basis, according to Wear, the value of informed consent is found in what it might add to the therapeutic goals of the clinical encounter, rather than any ethical value which might be intrinsic to the consent process.

In Wear’s event model, obtaining informed consent has distinct stages of physician disclosure and patient consent. For the content of disclosure, Wear follows the ‘law’s guidance’ regarding the specific types of information that any informed consent should incorporate. He suggests informed consent should include:

\begin{quote}
the patient’s overall medical condition, the specific problem for which treatment is recommended, the treatment recommended with its attendant benefits and risks, any alternative modalities, and the prognosis without treatment.\textsuperscript{22}
\end{quote}

\textsuperscript{20} Wear, S. (1998), p 100.
\textsuperscript{22} Wear, S. (1998), p 102.
Wear’s concession to broader notions of patient individuality is to include contextual information about patients’ past medical history and ‘the identification of ways in which it may have caused or contributed to the problem at hand’.\textsuperscript{23} The overriding focus of Wear’s event model is to advise (for the benefit of the doctor) what sorts of information should be given, and how and when it should be delivered. The role of the doctor is to understand the patient’s condition and to provide opportunities for the patient to develop a similar understanding. The scope of the doctor’s duty to understand the patient’s world view is defined by the doctor determining whether the patient understands the information given by the doctor.

The second overall stage of the event model is patient consent labelled by Wear as ‘assessment, clarification and patient choice’.\textsuperscript{24} He suggests:

\begin{quote}
It should be emphasised that this stage is the one place within the clinical encounter where the patient essentially directs the interchange, in effect dictating the level of detail by his or her responses, as well as by the sorts of questions he may ask.\textsuperscript{25}
\end{quote}

At this stage in the event model the corresponding duty of the patient is to ‘inject whatever subjective concerns he may have into the event’.\textsuperscript{26} Wear’s model reflects assumptions about doctors’ and patients’ roles detailed in Emanuel and Emanuel’s informative model. That is, the role of the doctor to provide all the available facts and the role of the patient to determine what treatment to choose based on their own subjective values and factual preferences. The underlying conception of autonomy stated in Emanuel and Emanuel’s informative model and gleaned from Wear’s event model is one of patient self determination, insofar as they voice any concerns about the information, the scope and content of which is determined by the doctor.

Wear gives primacy to the therapeutic goals of medicine. His main thesis is that if the informed consent debate is placed within the context of the realities, needs and opportunities of the physician/patient encounter, then informed consent will automatically be aligned with the goals of treatment encounters, which is to have the best possible outcome for the patient. Wear’s practical approach and strong alignment and sympathy for the realities of clinical

\textsuperscript{24} Wear, S. (1998), p 123.
\textsuperscript{25} Wear, S. (1998), p 123.
\textsuperscript{26} Wear, S. (1998), p 123.
practice are evident in his promotion of the value of patient compliance and therapeutic outcomes.

A related premise of this clinically focussed argument is that different types of treatments require different goals of treatment, thereby promoting differing levels of significance of informed consent in the clinical setting. For example, he suggests there are some treatments that are so clearly indicated (or required) in the view of the treating practitioner, that it is superfluous to consider issues relating to obtaining informed consent. In Wear’s view, as treatment approaches the ‘clearly indicated’ case, participation in informed consent procedures becomes increasingly trivial and both ‘patients and physicians might well legitimately feel they have more important tasks before them’. Wear makes no attempt to probe below the surface of the treatment encounter, or to examine attitudes and assumptions about the value of autonomy or the basis of the doctor/patient relationship underlying medical decisions. His approach is to tinker with what would appear on the surface to be straightforward medical interventions, and to judge requirements for patient input or choice to be measured against this unexamined and unchallenged interchange. Similarly, his description of the various needs of patients is based on the way patients present themselves and ask questions, without enquiring as to what factors might affect such communication. He suggests that patients’ views may be represented by a spectrum. At one end, the patient may be the type of person who is compliant within the treatment encounter and has views such as ‘do what you think is best and you’re the expert’. At the other end of this spectrum is the questioning or non-complying patient who says things like ‘give me all the information I need to make a decision’. In this model the level and content of the response of the clinician is dictated by the verbosity and assertiveness, or otherwise, of the patient.

The practical message to be taken from Wear is that obtaining a patient’s informed consent is a valuable activity because it may enhance the outcome of the treatment, it may add value to the treatment, and it will address legal requirements. Wear does not address the meaning of autonomy and how to honour that meaning in clinical practice. Rather, he takes the package of informed consent to the clinical setting and slots it into available places within the clinical encounter, with very little disturbance to the otherwise calm waters of clinical practice based on physicians’ overall decision-making authority.

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A transparency model (Brody)

Like Wear, Brody gives guidance regarding the content and amount of information that should be conveyed in clinical situations, based on an analysis of the contextual requirements of primary care medicine, and the accountability requirements of legal standards. The stated aim of his model is to resolve the tension between the objectivity required by retrospective legal examination of a treatment encounter and the subjectivity of the patient/doctor’s conversation. Brody proposes his model as ‘a doable task’ for practitioners and one that ‘allows courts to review appropriately.’

Like Wear’s event model, it tends to focus its main message on what a doctor should do, rather than what a doctor should think about.

According to Brody’s transparency standard, adequate information has been disclosed when a reasonably informed patient is allowed to participate in the medical decision to the extent that the patient wishes and when the physician’s basic thinking has been rendered transparent to the patient.

Reasonably informed consists of two features. First, disclosure should not only contain the treatment decision, but the basis for the decision. Second, there should be space for the patient to ask questions about such disclosure. The actions required of a physician following this standard are outlined by Brody in three steps:

1. The physician must share her thinking with the patient;
2. She must encourage and answer questions;
3. She must discover how participatory the patient wishes to be, and facilitate that level of participation.

In effect, Brody’s model is emphasising the obligation of practitioners to disclose to the patient how they (the doctor) have made an autonomous decision, including their reasoning, values and (biomedical) beliefs influencing their decision-making. He states:

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Essentially, the transparency standard requires the physician to engage in the typical patient-management thought process, only to do it out loud in language understandable to the patient.\textsuperscript{35}

Brody’s transparency model enhances and clarifies the obligation of a practitioner to give more information to their patient about what and how they are thinking. However the model does not enhance and clarify the obligation to engage equally with the patient, nor does it promote enquiry about the patient’s actual capacity to choose. Brody assumes that information disclosed in a transparent way will allow greater and more meaningful information to be available for patients to consider before making a treatment choice. His emphasis on the communicative actions of the doctor result in little emphasis on the obligation of practitioners to actively seek or to reflect upon patients’ actual values, beliefs, desires and capacities for contribution.

Brody does not specifically link his transparency model to the ethical ideals and meaning of autonomy. When compared to the ideals of an ‘ethically enriched informed consent’, Brody’s transparency model does not incorporate the ideas of reflection and examination of beliefs and values that contribute to and affect a person’s autonomous decision-making. To the extent that it emphasises the action required from the perspective of the practitioner, it neglects (in relative terms) to mention how a practitioner should respect the autonomous contribution of the patient. In other words, it does not try to unpack the black box which is patient autonomy and what it means for the patient to contribute to a clinical decision from a position of autonomy and self-determination.

The transparency model is useful as a practical model to increase awareness of what should be influencing clinical decision-making, because it provides prescriptive information to health professionals about the type of information that should be given to patients. It provides a positive obligation on practitioners to reveal more information, a deeper layer of information, so that patients are more ‘in the picture’, and know more about the ‘rules of the game’. However, in the transparency model, Brody does not advocate how a practitioner should go about examining factors and influences that may prevent patients from actively participating even in the presence of practitioner transparency.

Shared decision-making model (Charles et al.)

Charles et al. define shared decision-making as:

A mechanism to decrease the informational and power asymmetry between doctors and patients by increasing patients’ information, sense of autonomy and/or control over treatment decisions that effect their wellbeing.\(^{36}\)

Although this definition does not include the process of informed consent, the authors suggest that the requirements of informed consent seem ‘to imply at least a minimum of shared decision-making in the form of patient consent to treatment prior to any intervention.’\(^{37}\) The necessary components of a model of shared decision-making are defined by Charles et al. as the exchange of both information and treatment preferences between a physician and patient, and agreement by both parties on the treatment to implement. They identify four characteristics which are the minimum or necessary pre-conditions required to afford a given clinical interaction the status of ‘shared decision-making’:\(^{38}\)

1. Shared decision-making involves at least two participants – the physician and the patient.
2. Information sharing is a pre-requisite to shared decision-making.
3. Both parties (physician and patient) take steps to participate in the process of treatment decision-making.
4. A treatment decision is made and both parties agree to the decision.

In qualifying the first characteristic the authors acknowledge the potential influence of family, friends and advisers of patients and similarly the influence and involvement of other health team members. In relation to the second characteristic, they highlight some barriers to the requirement of sharing information. For example, they suggest that the type of information that is most often sought from patients by physicians is frequently limited to information that primarily aids the physician’s identification of treatment options.\(^ {39}\) Related

to this, patients often fail to express their real preferences for information because of relative
disempowerment or lack of knowledge of what should or could be asked. The authors
suggest that physicians should therefore be mindful of the groundwork needed to facilitate
patient participation, such as establishing a conducive atmosphere (so that patients feels
their views are valued and needed), actively eliciting patient preferences and disclosing
information in an unbiased, clear and simple way. Once information has been given, the
third key characteristic identified is the role of the physician to assist the patient in weighing
up the risks and benefits and to seek to clarify any misconceptions the patient may have.\textsuperscript{40}

The second and third characteristics above, are more in tune with the ideals of an ethically
enriched informed consent process outlined in chapter two. The process of information
exchange is linked to an idea of a patient’s right to receive the information as well as their
capacity to receive it. The giver of the information respects not only the autonomous right
to receive the information but the autonomous and individual capacity to deal with the
information, given any confounding and contextual features of the particular situation.

The fourth characteristic identified in the shared decision-making model is the importance of
mutual agreement. This implies some give and take from both parties. For example, the
physician may not entirely agree with the patient’s choice, ‘but agrees to endorse the
patient’s choice as part of a negotiated agreement in which the patient’s views count’.\textsuperscript{41}
This compliance, on the part of the physician, would presumably be ultimately limited by
how far they are prepared to forego their decisional authority and this is not clearly
explained by the authors. It is this (less well articulated) characteristic which goes to the
heart of what it means in a practical sense to respect a person’s autonomous decisions in a
clinical context.

In a later paper, Charles et al.\textsuperscript{42} further develop their shared decision-making model by
comparing the actions and reflections required by their model with those required by
Emanuel and Emanuel’s paternalistic and informative models. The authors suggest their
four criteria are not so prescriptive that patients’ individual constructions of their illness
experience or the individual nature of patient/doctor relationships are ignored. They suggest
that as a set of criteria, these four steps offer an alternative between the paternalistic model,

encounter: revisiting the shared treatment decision-making model. Social Science &
Medicine, 49(5), 651-661.
where the doctor gives the information but retains control, and the informative model where again the doctor gives the information, but the patient controls the decision-making.\textsuperscript{43}

The shared decision-making model developed in their 1999 paper offers a framework and, ideally, according to its authors, a flexible approach allowing physicians to structure the decision-making process ‘so that individual differences in patient preferences can be respected’.\textsuperscript{44} It introduces more conceptually based ideals of reflection that promote mutuality and equality of decision-making. In this way the authors provide more answers to the questions of how a health practitioner should deliberate about patient autonomy in a clinical context.

However, their model remains, like Brody’s transparency model, largely a model which analyses and describes the actions needed to fulfil an ideal of shared decision-making. It does not clearly or systematically develop an underlying theory of values and behaviour upon which the key characteristics are based, other than to point to the changing expectations of law, ethics and society.

The following two models I have categorised as reflective models of practice because they provide a theoretical background which is conceptual in nature, and which provides a richer theoretical base of ethical theory upon which to describe a range of appropriate actions.

\textit{The process model (Lidz et al.)}

Lidz et al. discuss two overall models of implementation of informed consent.\textsuperscript{45} They begin with an event model, which, like Wear’s model emphasises disclosure of complete and accurate information, material to the particular patient and with an eye to satisfying legal requirements. Obtaining a patient’s informed consent according to the event model, means the communication is directed at informing a patient and then obtaining their consent at a particular point of time in the interaction.\textsuperscript{46} Importantly, their discussion of the event model appears to be designed to highlight the contrast between it and their preferred option, the process model. Whilst the process model, according to these authors, attempts to integrate information disclosure into the routine and continuing dialogue between a doctor and

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patient, the event model may be regarded as merely ‘an extra step, being the procedure of obtaining informed consent, into otherwise unchanged decision-making.’\(^{47}\) They suggest that the event model is attuned to the requirements stipulated by law, in particular its emphasis on disclosure of material information as a discrete event, and is linked to the administration of a treatment. The authors suggest that this model is limited in its scope and therefore its usefulness as a model of informed consent:

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\text{(the event model)…is not directly concerned with improving the quality of the decision-making process or the patient’s comprehension of the treatment; rather, the emphasis is on the physician’s provision of the information that a hypothetically rational person would want.}\(^{48}\)
\]

Their second model, the process model, fits the criteria of a reflective model because it provides more background knowledge about theoretical assumptions that contribute to the idea or meaning of the practical phenomenon of obtaining informed consent in clinical practice.

Lidz et al. propose three conditions to be met before the process model can be implemented. The first is to recognise and delineate roles of both the health professional and the patient. The role of the patient, according to these authors, is as a valid member of the treatment team with particular expertise and knowledge of the history and context of their complaint. More specifically, the patient’s role includes an ability to evaluate and assess subjective symptoms, an ability to initiate the provision of health care and a capacity to be responsible for implementing self care and lifestyle changes.\(^{49}\)

The second condition is an awareness that patients and health professionals may hold different values and beliefs associated with different models of health and illness. Awareness of the effects of different starting points in basic views about health and illness means that one of the tasks of a doctor is to enquire about the patient’s health beliefs and views and to adjust their discussion accordingly. Related to this is the third condition which suggests the need for clarification of the relative values and expectations held by the doctor and by the patient about the illness and treatment. The action required to fulfil this condition is one of mutual sharing of information, both giving and receiving. The attitude required is one of respect for a patient’s ability to reflect and the need for time and

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\(^{47}\) Lidz, C., Appelbaum, P., & Meisel, J. (1988), p 1386. Their event model shares the same characteristics as Wear’s event model discussed earlier in this chapter.


appropriate conditions which might allow such reflection, as it relates to any proposed treatment.

Based on these conditions, the patient begins to emerge from the shadows and comes into sharper focus as a person who is able to contribute values, knowledge and beliefs, which in turn are considered to be valuable and required commodities within a treatment encounter. After outlining the necessary pre-conditions, Lidz et al. describe the actions required to implement those conditions. These involve a process of mutual monitoring incorporated into routine ongoing dialogue between patients and health professionals. For example, they suggest that the monitoring should include each person’s understandings of illness including benefits, risks, underlying values and treatment expectations.\(^{50}\)

The steps involved in implementing the process model begin at the commencement of the treatment where the health professional establishes their area of expertise and responsibility. This allows the patient scope and information to direct their questions appropriately. In the second phase of the treatment involving definition and diagnosis of the problem, Lidz et al. suggest that the health professional uses open ended questions and listens to the patient’s responses. The guiding assumption for this step in the process is that the patient has relevant expertise in relation to how their illness interferes with their functional capacities.\(^{51}\)

During the discussion about the proposed treatment and any associated risks and benefits, Lidz et al. suggest health professionals should ensure they find out about the patient’s goals and use this information in the discussion about which treatment is likely to achieve these goals, with due consideration of risks, benefits and, importantly, alternatives. They also refer to the importance of not taking the patient’s first response at face value and that some effort should be made to repeat enquiries about patients’ goals, their views of their problem and their preferred treatment options.\(^{52}\) Transparency of planning regarding treatment options should also be provided as an opportunity for patients to make sense of different treatments.

Whilst the model advocates a number of practical actions they are not described only as prescriptive actions with which practitioners should comply. Instead, the actions are linked to attitudes of respect for equality and collaboration and, most significantly, they emphasise the importance of enquiry into a patient’s capacity for collaboration.

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The process model is thus built on the idea or vision of active patient participation in decision-making. The assumption at the outset is that the patient’s values and beliefs are integral to the exchange of information, an assumption which is more resonant with the ideals of ‘ethically enriched’ informed consent.

**Conversation Model of Interaction (Katz)**

In developing his conversation model, Katz\(^{53}\) begins at a different starting point to the previous authors discussed in this chapter. Wear and Brody take the issue of informed consent and discuss how doctors can fit it into their usual practices. Charles et al. and Lidz et al. introduce ideas of reflection about the implementation of informed consent, which have the effect of facilitating a review of the nature of medical practice, attitudes and underlying values. Katz begins by questioning those underlying values and past practices and from this basis argues that what I have termed ‘ethically enriched’ informed consent or informed consent which is explicitly based on ethical theories of autonomy, cannot be accommodated within such a medical practice paradigm. Hence he suggests the paradigm needs to change.

Katz refers to ‘doctors’ millenia–long tradition of solitary decision-making’.\(^{54}\) Resistance to change, according to Katz, is not solely based on unwavering certainty that ‘doctor knows best’, but on an awareness (conscious or subconscious) of the tensions inherent in sharing decisions with patients, such as the pervasive belief in professional authority and freedom from lay control.

Katz does not set out to specify how physicians and patients should converse with each other. That is, he does not outline a practical conversation model as such. Instead, Katz suggests a need for active reflection on values and motivations held by health professionals, and how they may influence implementation of informed consent.

He points to four broad areas for reflection contained within the idea of a conversation model.\(^{55}\) First, that there is no single way of living with health or illness, or (translated to physiotherapy terms) disability or dysfunction. Alternative choices in medicine (and physiotherapy) must therefore be explained. Second, both physicians and patients bring

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their own vulnerabilities to the decision-making process, and as such ‘both are authors and victims of their own individual conflicting motivations, interests and expectations’. The third area is that parties should relate to each other as equals, rather than from the obvious and traditional pattern of parent-like caregiver and child-like receiver of care. Finally, there should be a willingness to explore both reasonable and non reasonable decisions, values and judgments on the part of both the doctor and the patient.

The major assumption upon which Katz bases his idea for the capacity for meaningful conversation between patients and doctors rests in a particular understanding and assumption of patient autonomy and right to self determination. Katz recognises that patients’ rights to self determination have increasingly become part of the rhetoric of ethical obligations, the legal basis of informed consent, and as a justification for patient participation in medical decision-making. He suggests that the arguments of the proponents of patients’ rights, for patients to more fully participate in decision-making, flow from theories of moral and civil autonomy and autonomy of the will. In contrast, the opponents argue from a practical implementation viewpoint, that patient choice is often meaningless because of the effects of illness on a patient’s ability to actually participate. Both sides, according to Katz, have flawed arguments. The proponents, because they fail to integrate abstract notions of rights with human psychological capacities for autonomous choices, and the opponents, because of a failure to not integrate or develop any systematic theory of psychology of the physician/patient relationship. For example, Katz claims there has been a failure of opponents to consider whether any incapacities of patients, in the area of decision-making or capacity to be autonomous, have in fact been engendered or reinforced by the physician’s conduct itself.

Katz makes an important distinction between a patient’s right to self determination, defined as the right of an individual to make their own decisions without interference from others, and a patient’s autonomy, which Katz defines as the capacities of persons to exercise their right of self determination. By making such a distinction, Katz attempts to link and inform the assertion of rights of self determination to the human psychological capacity for exercising those rights.

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Katz claims that self determination comprises two intertwined component ideas: the external component or the choice of action; and the internal component which involves thinking or reflecting about choices prior to action. His idea of psychological autonomy reflects this latter internal component of self determination:

psychological autonomy refers to the capacity of persons to reflect, choose and act with an awareness of the internal and external influences and reasons that they wish to accept.

By distinguishing between the internal and external aspects of self determination, Katz opens up the possibility of assessing the extent of respect needed for a person’s capacity to think about choices, and not just the more obvious and externally focussed question of providing freedom to make a choice.

Taking Katz’s distinction into account, if the internal and external content of self determination is given equal value, then health professionals would be under an obligation to not only disclose information that enabled a patient to make an ‘external’ choice, but also to converse with the patient about what they are thinking about in relation to their ‘internal’ choices (including their fears, misconceptions, conceptions and hopes). The practitioner would equally be under an obligation to disclose what values and ideals influence him or her in offering the particular treatment choice.

Katz’s rationale for a view of autonomy grounded in psychological theory is detailed. However it is important to discuss it here, as it provides the structure underlying his model of what to think about, rather than what to do. Katz refers to the influence of psychological theory, and in particular psychoanalysis, which asserts that conceptions of psychological autonomy must take the unconscious into account. If we accept, as Katz suggests we should, the importance psychoanalysis attributes to the unconscious, then there is the possibility that we will be freer to acknowledge unconscious motivations that influence the decisions we make to explore the sources of such motivations and to appreciate their influence on our thought and action.

Katz refers to two psychoanalytic concepts that are important to his functional definition of psychological autonomy. The first is the impact of unconscious forces on thought and action. These include potential conflict between conscious and unconscious motivations

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‘that can express motivations that have less to do with one’s current situation and more with unresolved problems from earlier years.’

Katz’s second psychoanalytic concept (based upon Freud’s categorisation of primary and secondary mental processes) is simplified as rationality-irrationality determinates. According to Katz, rationality refers to the impact on thought and action of such factors as consciousness, reality needs, time perspectives and reflective thought, whereas irrationality refers to the impact on thought of unconscious impulses, fantasies, confusion of past and present realities and a disregard of facts.

Katz believes the distinction between an understanding of the impact of the rational and the irrational facilitates knowledge of the capacities for adaptation to the external world by accounting for how a person is able to take reality into account or ‘give an account of the conflicts between their inner and outer worlds to themselves and others.’

Katz suggests that doctors should make an effort to embark on reflection with patients and self reflection about the conscious/unconscious and rational/irrational bases of choices of themselves and their patients. The assumption behind this suggestion is that greater consciousness of the determinants that influence thought and action will enhance decision-making. The implications for accepting the influence and interplay of ‘consciousness and unconsciousness’ and ‘rationality and irrationality’, is a recognition of the potential for tension and disharmony in human interaction.

According to Katz, the values of the doctor are often homogenised to a catch all phrase of ‘medical judgment’ and should also be examined, or at the very least the doctor should be aware of the values behind the best medical treatment he or she is proposing. Moreover, he maintains that physicians have previously tried to justify their preference for patients’ trusting silence rather than conversation, in the belief that physicians and patients have an identical interest in medical matters.

Katz describes the trust associated with the idea of assumed mutuality of interest, as the type of maternal caring between mother and child, particularly when the child is at a non verbal

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stage of development, and the trust of the child is based on the mother’s care through her deeds.\(^69\) He suggests as an alternative that the trust associated with probing different expectations between each patient and doctor is a more adult interaction where both parties are equally valued. Again Katz is advocating for a recognition of the (internal) influence of both physician and patient values and an examination of the traditional and largely unexamined notion of patients’ implicit trust of the view of their doctor. The reflective action required is to examine and define the values and beliefs underlying the doctor/patient relationship.

Katz does not produce a list of elements which should be included in a conversation between doctor and patient as a way of guiding doctors looking to implement informed consent:

> I have not tried to specify in any detailed fashion how physicians and patients must and can convene with each other. Instead I have tried to identify the pre-conditions for informed consent and to draw attention to the consequences of its rejection.\(^70\)

His two main pre-conditions for informed consent are first, a greater understanding and awareness of the values and assumptions which underpin clinical practice, and second an expanded conception of the meaning of autonomy.

He suggests that the values and assumptions underpinning clinical practice, and which should be brought to the surface are the idea and general acceptance of physician authority of decision-making within the clinical encounter, the relative values placed on autonomy and beneficence, and the inherent uncertainty of many medical decisions.\(^71\) He asserts that when these values are openly acknowledged alongside an understanding of autonomy, which encompasses both freedom to make choices (external autonomy) and capacities for thinking about choices (internal autonomy), then physicians will be in a position to implement informed consent.\(^72\)

Although Katz does not specifically refer to either Dworkin or Young, in his conception and definition of psychological autonomy, he encompasses many of their ideas about the need to

\(^69\) Katz, J. (2002), p 100.
\(^71\) Katz, J. (2002), p 86.
\(^72\) Katz, J. (2002), p 86.
recognise individual capacity for reflection and the need to be aware of the external influences which may impinge on a person’s autonomy.\textsuperscript{73}

In summary, the model of informed consent developed by Katz is less prescriptive than previously discussed models because it promotes thinking and reflection, which could be applied to different types of treatments and clinical scenarios rather than guidance as to what should be said in the exchange. In so doing, it incorporates the philosophical meaning of autonomy into clinical communicative practice by requiring a health practitioner to start from a position of self knowledge and reflection in order to respect and promote their patients to do the same in any clinical decisions.

The style and content of communication advocated by Katz covers all the elements of previous action based models and reflective models. It has the effect of downplaying the responsibilities of practitioners to comply with obligations of specific disclosure but at the same time it brings to the foreground the role of the patient, the needs of the patient, and the relationship between the patient and the practitioner.

\textbf{Summary of the five models and introduction to their practical application}

At the beginning of this chapter, I outlined two avenues of enquiry which I used to guide my review of models of informed consent. The first concerned the way the models incorporate ethical theories of autonomy. The second concerned the applicability of the models to the clinical physiotherapy context. My review of the models on the basis of the first enquiry has provided justification for my placement of each model along the action/reflection spectrum.

Models which more closely reflect an ‘ethically enriched’ process of informed consent emphasise the importance of what to think about, more that what should be said or done. They include the conversation model by Katz and process model by Lidz et al. Both these models emphasise processes of reflection about the meaning and value of autonomy to guide actions, rather than the interpretation of autonomy into specific communicative actions.

\textsuperscript{73} Katz does not refer to occurent and dispositional autonomy as Young does. However, in his discussion of external choice he refers to the extent of respect for a patient, which, I suggest, is similar to Young’s depiction of whether a person’s general disposition should be respected or just whether their particular choice being put to them in the clinical encounter should be respected.
On the basis of this review I contend that the ideas behind the conversation model best incorporate ideals of ‘ethically enriched’ informed consent because they attempt to unravel the strands of meaning of what respect for autonomy might entail within a clinical interaction. Although not explicitly drawing from particular theories of autonomy, Katz refers to ways of thinking about its meaning as a way to guide action. This is the same action required by referring to ethical theories of autonomy as a way of guiding informed consent. Importantly, as Katz states above and I have implicitly argued by reference to the layered nature of the iceberg framework, incorporation of a deeper understanding about autonomy is an important component in understanding and defining informed consent.

The final section of this chapter completes the second avenue of enquiry. In it, I examine the five medical models as they are applied to a hypothetical clinical scenario. My specific interest is twofold. First I am interested in testing whether the models are applicable to a typical physiotherapist/patient encounter. That is I will ask ‘how coherent is each model within the practical clinical context of providing physiotherapy in a private practice setting?’ Second, I am interested in whether application of the models to a clinical scenario changes the practical implementation or process of informed consent. Here I am interested in the features of informed consent which become apparent when each model is applied in practice. The answer to this second question is especially pertinent to my examination and analysis of clinical communicative practice because it will sensitise me to a variety of features of communicative practice which reflect processes of informed consent.

Whilst physiotherapists have relied upon medical ethical literature to define and shape their ethical and professional values, they have not similarly developed or relied upon models of practice which attempt to link ethical theory with clinical practice. The following case scenario of Mary and Sonia is one that I developed as a result of the synthesis of my current research interest, knowledge of the physiotherapy undergraduate curricula, experience in teaching in both undergraduate and postgraduate courses and a personal knowledge and clinical experience of the nature of physiotherapy clinical practice. The case was also used as part of a paper in which I reviewed the physiotherapy ethics literature concerning the relationship between autonomy as an ethical theory and informed consent as a clinical process.74

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Application of models to physiotherapy practice

The Patient

Mary is a 35 year old secretary who has suffered from recurring episodes of low back pain over the past six years. The pain is associated with stiffness, is always worse at the end of the day after sitting at the computer, and is relieved by lying down or walking. Mary has never been a very active person. She was not very skilled at sport and in fact has uncomfortable memories of being teased as a teenager for her lack of coordination and ability to participate in sports and aerobic classes. Mary’s low back pain is becoming more constant, so she decided to consult a physiotherapist (recommended to her by a friend). Mary has never been to a physiotherapist before.

The Therapist

Sonia graduated as a physiotherapist five years ago. She works at two practices, one a sports therapy centre and the other a private practice in the outer suburbs of Melbourne. Sonia has attended a number of weekend courses since graduating. She is aware of the expectation to continually update her knowledge and skills. The idea of patients contributing to their own care and being actively involved in managing their own problems appeals to Sonia. She has always valued fitness and self motivation and is a firm believer in the power of self discipline. Two weeks ago she attended a course on abdominal muscle stabilisation techniques.75 In this course Sonia learnt how to demonstrate and teach deep abdominal muscle strengthening exercises. The weekend course also reviewed the evidence in the literature demonstrating the long term effectiveness of regular abdominal muscle strengthening for decreasing low back pain.76 Traditional “hands on” approach was seen to develop patient dependency.77

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75 In the current physiotherapy research context in Australia, there has been a steady rise in research interest in this area. See for example Hodges, P. (2000). Does strengthening the abdominal muscles prevent low back pain? Journal of Rheumatology, 27(9), 2286-2287; Hungerford, B., Gilleard, W., & Hodges, P. (2003). Evidence of altered lumbopelvic muscle recruitment in the presence of sacroiliac joint pain. Spine, 28(14), 1593-1600.
The Treatment

Mary arrives at the sports therapy centre where Sonia works. Sonia assesses Mary’s back by asking a series of questions related to the nature of the low back pain, site of pain, duration, time of occurrence, severity, aggravating and easing factors. Sonia then asks Mary to perform a number of movements of her back and again checks the effect of the movements on Mary’s back pain. Sonia then explains to Mary what she thinks Mary’s problem is and how she intends to treat it. Sonia has decided that Mary’s problem is caused by too many hours of poor posture during the day, sitting at the computer. This has resulted in gradual loss of movement of the joints in the lumbar spine and a decrease in strength of the deep supporting muscles.

Sonia has decided that Mary is a perfect candidate for the deep abdominal muscle exercises she recently learnt at the weekend course. Prior to attending this course, Sonia may have given Mary a different treatment, that is, she would probably have given Mary some hands on manual therapy, consisting of mobilisation, massage and some local heat therapy. Sonia proceeds to explain to Mary the long term benefits of performing the particular exercises and how they will gradually reduce her pain. She demonstrates how to do them and gives Mary an exercise sheet and schedules another appointment for the following week.

Application of the Informed Consent Models

Providing patients with an opportunity for choice and obtaining their informed consent to treatment will most likely not have been covered in any of the courses that Sonia has recently attended. Sonia recalls the idea of obtaining a patient’s informed consent to treatment as being related to treatments of cervical manipulation where there are known associated risks.

Wear’s Model

If Sonia had instead read Wear’s model of informed consent, she may have reflected on how obtaining Mary’s informed consent may add value to the treatment outcome. Sonia would be aware that if Mary was given a specific opportunity to agree to the treatment, then she would more likely adhere to the exercise regime. However, according to Wear’s model, a treatment such as this with strong evidence to support it, would be classified as clearly indicated, and therefore the need for Mary’s participation in decision-making would be
fairly minimal because there are few side effects, the exercise treatment has been shown to be effective and Sonia has the relevant skills to give the exercise. If Wear’s model was implemented, Mary may not be given any treatment options and she would therefore not be aware of any choice involved other than to agree with what Sonia has decided to offer. Mary’s values and understanding of her illness or treatment preference would most likely not be sought.

Wear’s event model has a pragmatic emphasis. Application of his ideas would not alter Sonia’s focus on choosing and providing an evidence-based treatment program on the basis of her knowledge and skill. Given that there is very little risk of injury associated with the treatment and given that the treatment is likely to result in the best possible physical outcome, Wear’s ideas of informed consent could easily be incorporated into this treatment and would not alter the flow of treatment as originally determined by Sonia. The features of informed consent represented by Wear’s model applied to this treatment scenario would be a therapist providing beneficent treatment with little challenge to the provision of therapist-determined advice and management.

**Brody’s Model**

Following Brody’s model, Sonia would need to transparently provide information and explanation about her reasoning processes to Mary, according to the notion of a reasonably informed patient, and based on Mary’s wishes. In order to achieve this, Sonia would need to be more transparent in her clinical reasoning than she has been thus far. Sonia may interpret this transparency to mean informing Mary that there are treatment choices, namely, manual therapy (with the consequent short term relief and relatively poor evidence for effectiveness), or deep abdominal muscle therapy with strong evidence for its long term efficacy. Sonia may also interpret transparency to mean clear and informative explanations about her reasoning processes.

According to this model, there is scope for a range of interpretations of the meaning of transparency. For example, Sonia may interpret it to mean that she must explain in some detail the nature of exercise therapy, the evidence that supports it, strategies for implementation and possibly the underlying values of fitness and patient self contribution. Transparency may also be interpreted to mean the range of treatment alternatives, risks and benefits. Sonia may also interpret the need for transparency to include more information about the scope of patient contribution. This would include information about how the
exercise regime requires a commitment to adhere to an exercise schedule and the need to alter postural habits and work routines.

According to the transparency model, Sonia might encourage Mary to ask questions about the information she had been given and she would also add a further question enquiring about how involved Mary would like to be in any treatment decisions, or whether she would be happy to leave it up to Sonia to make the decisions. Sonia would be satisfied that if a legally-based examination was applied to the treatment there would be objective evidence of communication that was informative and transparent and that Mary would have been given a direct opportunity to provide input.

Brody’s model requires more information about processes of clinical decision-making to be provided by Sonia to Mary. It also suggests that Sonia should question Mary as to her preferences about receiving information. Brody’s model is clearly applicable and coherent with the goals of physiotherapy treatment and would require possibly only minor adjustments, such as a more planned strategy of providing transparent information to a patient about the clinical decisions to be made by the therapist. Applying Brody’s model, the features of the informed consent process would be recognised by a therapist providing explanations about their reasoning and clinical decision-making processes. Another feature would be a willingness to provide further information should a patient request clarification or express a desire for more information.

Charles et al.’s shared decision-making

If Sonia had recently attended a course on shared decision-making run by Charles et al., she would need to spend some time reflecting on how she intended to communicate information to Mary and how she might facilitate a more equal exchange of information between herself and Mary. Sonia would be aware of the differences in styles and methods of communication between shared decision-making, paternalistic communication and adherence to an informed model of communication. She would be more aware of the need to include Mary in the decision-making process so that on an objective view of the exchange, information could be seen to have flowed in both directions and not just have been one way.

First, Sonia would ask Mary about her views about the cause of her low back pain. Second, Sonia would either tell Mary about her expectations of her role as a patient in sharing information with her, or she may alter her line of questioning to be more open, so that Mary is encouraged to provide more information about her problem, how it affects her and what
she believes are the likely causes. At this point it is possible that Sonia may find out about Mary’s dislike of exercise, based on her past experience of failure as a teenager. At the same time Sonia would give her view about the treatment, including her preferences and the basis for her preferences. Finally, Sonia would seek to reach a consensus with Mary about which treatment should be followed.

Implementation of the communicative strategies suggested by Charles et al relies on the therapist recognising the need for a decision to be made and understanding how to resolve differences between their preferences and their patient’s preferences. For example, if Mary disagrees with Sonia and decides on the manual treatment rather than the exercise therapy, Sonia will need to decide how far she is prepared to compromise her preferences to follow Mary’s preferences. If Sonia makes the judgment that Mary’s views and lack of motivation to exercise are irrational, she may decide to overrule or ignore Mary’s information and proceed to provide exercise therapy. Similarly if Sonia decides that treatment of low back pain with abdominal exercises does not warrant implementation of a shared decision-making process, because there are no realistic therapeutic choices, then she may not see a reason to consider the steps involved in the shared decision-making model. The course run by Charles et al. emphasised the steps involved in sharing decisions within a clinical encounter. Its focus was not on why and when such decisions were important.

Like Brody’s transparency model, the shared decision-making model could readily be accommodated in the clinical practice encounter. It requires a commitment on the part of the therapist to follow a process of communication that explicitly accommodates Mary’s contribution and positively aims to reach a collaborative treatment regime. The features of this model used as an informed consent model are more obvious than the previous two models. They would be recognised as more active questioning of the patient by the therapist. The process of decision-making and communication would be more collaborative with less emphasis on what the therapist thinks and more emphasis on what the patient thinks.

*Lidz et al.’s process model*

If Sonia were to follow the guidelines and explanation of a process model of informed consent, again she would need to devote some time to thinking about the nature of her relationship as a physiotherapist to Mary as the patient. Sonia would have to clarify their respective roles and to use this clarification to inform the type of communication that occurs. Sonia would view Mary as having an expert role in providing information about her
condition in addition to values and beliefs about her condition. In this spirit, Sonia would view Mary as having an independent but valuable role. Discussion of the exercise therapy treatment, the manual therapy treatment, risks and benefits, alternatives and consequences would occur on the basis of an ongoing process of mutual monitoring of the underlying values, motivations and expectations of both Sonia and Mary.

Attending the process model course would not provide Sonia with prescriptive actions to follow. Instead, the aims of the process model, to integrate information disclosure into the whole of the dialogue between patient and therapist, would alter the basis and purpose of the exchange. Whilst this would fit into the aims of the physiotherapy encounter, it would require an attitudinal shift on the part of Sonia as the therapist. The process model would be recognised by what was not present rather than specific features of the communicative exchange. According to this model the therapist would not obviously direct the treatment agenda by outlining treatment choices, or the reasoning processes underlying her diagnosis. There would not be an obvious division of expertise where the therapist provides an assessment, diagnosis and treatment and the patient accepts the advice and treatment passively.

Recognisable features of this model would include a more equal contribution between patient and therapist throughout the treatment and a general commitment to including the values of both patient and therapist to form part of the communicative exchange.

*Katz’s conversation model*

Attending a course on a conversation model by Katz would provide Sonia with even less in the way of specific actions. Sonia would need to reflect upon and come to an understanding of how obtaining a patient’s informed consent to treatment is based on a particular view of respecting their autonomy. Underpinning this, Sonia would need to have a deep understanding of the meaning and implications of respecting autonomy.

In relation to Mary’s case, Sonia would be aware that she needs not only to respect and provide opportunities for Mary to exercise a choice, but she must also be aware of the potential barriers that may restrict Mary in making any meaningful choice.

Sonia would need to reflect on the values and source of those values that motivate her preference for exercise therapy. For example, she could relate to Mary that the basis of the physiotherapy intervention of exercise therapy was scientific research evidence, an interest in long term results and a belief in the importance of patients managing their own condition.
Sonia may also relate that she has a personal preference for exercises as she has always valued self discipline for solving problems.

Having stated her values, both rational and non rational, Sonia would then need to demonstrate an equal interest in Mary’s values and preferences. Enquiries such as ‘How do you feel about following the treatment with a regime of exercises including active changes to your posture at work? Tell me about your expectations of this treatment? Do you share my view of self discipline and the value of exercise or do you have another view?’ If the questions are asked in the spirit of discovery and equality, then the exact wording is not necessary to elucidate. Sonia could instead ask herself ‘What question should I ask if I wish to find out about Mary’s values, what her thoughts and expectations are in relation to this treatment, and how she would like to be involved and to participate? Sonia would ask questions because respect for patients’ autonomy, both rights and capacities, would be seen as a valuable commodity in the treatment encounter, on a par with achieving a measurable treatment effect or outcome.

Sonia would have a particular view of her relationship with Mary. It would not be the traditionally held view of the health professional/patient relationship. That is, it would not be premised on the view that Mary should trust in Sonia’s judgment, even if Sonia has the most up to date and evidence based treatment to offer. It would be based on premises which value equality within the exchange. Sonia’s work as a physiotherapist would not be solely to seek out signs and symptoms that accord with her ideas of treatment and intervention. Rather, she would need to widen the therapeutic perspective to understand and take into account reasonable and non-reasonable decisions, values and judgments of her patient.

In response to Mary’s view of exercises, Sonia would acknowledge that experiences of exercise and even other treatments are a valid source of information and influence on future treatments. Sonia may suggest the possibility of trying the exercises, despite Mary’s past experiences, and may explain how the deep abdominal muscle exercises do not require skills of dexterity and coordination associated with playing sport. Sonia may take account of Mary’s views by treating her with manual therapy for the initial treatments and leaving the door open for exercise therapy at a later date.

Like the process model advocated by Lidz et al., the conversation model does not provide a list of actions or suggest the types of communication which should occur. However the overall nature of the exchange would be characterised by a sense of equal standing between patient and therapist. There would be evidence within the interaction of the therapist actively
seeking ways to involve their patient and actively compensating for any barriers that may be restricting their patient’s ability to contribute as an autonomous patient. The main feature of the communication when Katz’s conversation model is applied is that the exchange is more like a conversation. Underlying this simplistic description is a set of values and assumptions about the conversation. They include an acceptance of the value of patient autonomy as an integral component of the therapeutic goals and communicative agenda.

**Summary of application of models and key points**

All five models could theoretically be applied to the physiotherapy clinical encounter and all of the models would result in some change to the content and style of the communication. This in itself is a significant finding and suggests that conscious application of the models of practice of informed consent proposed in the literature do, from a hypothetical perspective, alter the content and method of delivery of communication within a clinical encounter.

Applying Wear’s event model, therapists would be free to decide the most beneficial treatment available. Obtaining informed consent would be limited to obtaining patients’ agreement to the goals of the therapeutic treatment. Applying Brody’s model, the informed consent process would be recognised by greater explanation of therapists’ clinical reasoning and treatment justification. Patients would be expected to take advantage of therapists’ explanations to either agree, disagree or choose a different path. Features of an informed consent process according to the shared decision-making model would be evidence of both patient and therapist contributing to any treatment decisions.

Specific features of informed consent become less distinct in both the process model and the conversation model. They both rely on an attitudinal shift in the therapist. According to the process model, there would be evidence of therapists explicitly acknowledging and defining the role of the patient to add to the communication. The dialogue would be broader and include a discussion of patients’ values and interpretation of their condition. This discussion would be regarded equally as valid as a discussion about the diagnosis and proposed treatment from the therapist’s perspective. Similarly, in the conversation model, the communicative interaction would be characterised by evidence of an adult conversing with another adult. There would not be an obvious asymmetry of expertise, where the therapist gives expert treatment advice to a patient who passively receives it and complies with treatment requirements. Instead, the therapist would transparently discuss proposed
treatments, including underlying values and converse with patients about their underlying values and understanding. Expertise in Katz’s conversation model lies in a therapist’s ability to recognise and acknowledge both barriers and opportunities to involve their patient in the treatment encounter.

What is also apparent when each model is applied to a clinical scenario is that those models which advocate a particular type of action at a particular point in the treatment, such as Wear’s event model, Brody’s suggestions for transparent communication, or the steps involved in achieving evidence of shared decision-making, also leave room for avoidance of their specific application by the therapist. In other words, the more the models prescribe actions, the more they give practitioners a way of avoiding their ideals because of circumstantial differences in different clinical situations.

In contrast, the models that are less directive about specific types of communication, such as those proposed by Lidz et al. and Katz, potentially alter the communication and the process of obtaining informed consent more profoundly by their focus on underlying values, attitudes and meaning associated with respecting autonomy.

Most importantly, analysis of all five models of informed consent has provided an overview of different features of communication in the informed consent process, which will inform my empirical examination of therapists’ clinical communication with their patients.

Prior to that examination, in the next chapter I focus on layer three of the iceberg mode. I review the physiotherapy ethics literature and its interpretation and response to informed consent and autonomy.
CHAPTER 4: Informed consent and autonomy in the physiotherapy literature

Introduction

This is the final (layer three in the iceberg framework) of three chapters in which I provide a multilayered definition of informed consent prior to the empirical component of the research. In the previous chapter I examined five models of practice of informed consent, specifically developed to assist doctors to implement the process of informed consent. The extent to which the models incorporated the ethical theory of autonomy determined my categorisation of them as either predominantly prescriptive or reflective in approach. Based on a hypothetical case scenario, I found they were all applicable to a physiotherapy clinical context. However I identified different features of the informed consent process resulting from their application. The features ranged from specific strategies of communication from the therapist, such as the provision of more transparent information and ensuring the patient contributes to any decisions about the proposed treatment, through to less defined features. These latter features were evidenced by a commitment to enhancing patient involvement throughout the whole treatment encounter and an expectation that the communication would encompass a mutual exchange of underlying values, beliefs and aims of treatment.

In this chapter I focus on the physiotherapy profession’s response to informed consent. Whilst physiotherapy authors have not developed models of informed consent to aid the implementation and understanding of the process and obligation, there is a body of knowledge about ethics, ethical and legal obligations and communication in clinical practice. I analyse how the physiotherapy literature has discussed ethical and legal obligations of informed consent in clinical practice from two overall perspectives. The first concerns how informed consent and autonomy have been described and related to each other in the physiotherapy ethics literature. The second perspective is to examine how informed consent has been approached as a practical clinical obligation to communicate with a patient. On the basis of this perspective, I examine studies which have looked at the implementation of informed consent, and studies that have looked more generally at physiotherapy clinical communication. In this section I also examine the physiotherapy literature related to the process of ethical reasoning in physiotherapy practice. This literature, by definition, encompasses therapists’
interpretation and implementation of their ethical knowledge into strategies of clinical decision-making and communication.

By the end of this chapter, I will have reviewed the physiotherapy ethical discourse relating to autonomy, informed consent, clinical communication and clinical ethical decision-making. The review forms an important prelude to the empirical examination of clinical communicative practice and processes of informed consent.

**Physiotherapy Practice and the Development of Ethics**

Aligned with biomedical models of practice, physiotherapy initially began as an adjunct profession to medical practice. From the outset its clinical profile was modelled on the medical profession and in conformity with notions of ‘hard sciences’ included the adoption of scientific biomedical models of practice. In the earlier stages of the development of the profession therapists primarily relied on the clinical (and ethical) decisions of the referring doctor. The skill base was mechanistic and therapists valued good manual skills over and above autonomous practice and independent decision-making. As Stachura notes, a term of acclaim used by physiotherapists to describe a good clinician is that he or she has ‘good handling skills’.

Over the last two decades, this mechanistic skill base has evolved to an interest and examination of therapists’ clinical reasoning skills. Edwards et al. suggest two main reasons for this change in focus. The first is that as an autonomous profession, there is a requirement for increasing accountability of decision-making. The second relates to the importance of understanding processes of decision-making as an important source of learning in clinical practice. In the area of ethics, the physiotherapy profession has followed the medical profession in its reliance on the Hippocratic tradition as a basis for formulation of its code of

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5. Stachura, K. (1994), p 357. By this Stachura is referring to the ability of the therapist to massage or use their hands in some way to produce a physical benefit.
ethics. In physiotherapy the duty to help (beneficence) and the duty to avoid harm (non-maleficence) have been considered to be the most influential of the ethical principles.\(^7\)

The earliest draft of a physiotherapy code of ethics (drafted by the Chartered Society of Physiotherapists in Great Britain)\(^8\) was concerned more with rules of etiquette in relation to how to dress, and how to relate to fellow professionals rather than the rights of patients.\(^9\) Like other health professions, physiotherapy codes of ethics have developed in accordance with changing societal expectations, legal guidelines and increased professional obligations.\(^10\) In Australia, the Australian Physiotherapy Association (APA) has a code of ethics\(^11\) reflecting a framework of western moral philosophy,\(^12\) and derived from Beauchamp and Childress’s four cardinal principles (beneficence, non-maleficence, respect for autonomy and justice).\(^13\) This ethical framework has provided general guidelines for ethical decision-making by Australian physiotherapists for several decades.

As the profession has evolved and developed, in particular with the status of physiotherapy as a first contact service provider, the previous reliance upon referring doctors for clinical (and ethical) decision-making has been replaced by therapists themselves taking on those roles. In Australia, physiotherapists obtained primary health care or first contact status in 1976.\(^14\)

Changes in ethical knowledge and awareness of ethical issues relating to physiotherapy practice occurred initially as a result of increasing independence and autonomy as a profession.\(^15\) An important catalyst therefore, for discussion of ethical issues was the recognition that autonomy as a profession carries responsibilities of accountability in practice

\(^8\) Robinson, P. (1994). Objectives, ethics and etiquette. Physiotherapy, 80(A) 8A-10A.
and in clinical decision-making.\textsuperscript{16} This responsibility, according to Purtilo, includes the ability to recognise which components of clinical situations have a moral quality to them.\textsuperscript{17}

In a comprehensive retrospective analysis of physiotherapy ethical knowledge, Swisher\textsuperscript{18} found two broad types of ethical approaches. From ninety English language articles published in the period of review (1970-2000) 43.2\% used a philosophical approach (defined by Swisher as a concern with what people ought to do and how they ought to conduct themselves, as well as the rational basis for such decisions).\textsuperscript{19} A social scientific or descriptive ethics approach focusing on studying human ethical behaviour was used by 33.3\%. Of the 43.2\% of publications demonstrating a philosophical approach, 60\% used principles as a guide to ethical behaviour.\textsuperscript{20} The remaining publications used a combination of historical development (of codes of ethics) and theoretical models of expertise in physical therapy (including moral virtue) to discuss ethics.

Swisher found that in the period 1970-1979 physiotherapy authors focussed on the identity of the profession, including the role of the physiotherapist as an ethical decision maker.\textsuperscript{21} From 1980-1989 application of philosophical principles to ethical issues was the main focus and from 1990-2000, the changing relationship between physiotherapists and their patients was the dominant theme in the literature. In this latter decade, an increase in the use of a social scientific approach led to the development of theoretical models of ethical clinical decision-making.

The results of Swisher’s review of ethics knowledge in physiotherapy over three decades highlights steady growth in the body of knowledge of ethics.\textsuperscript{22} However her review also identifies gaps in the existing physiotherapy ethics knowledge base. Specifically Swisher found that few studies had attempted to define the ethical issues which physiotherapists


\textsuperscript{18} Swisher, L. L. (2002).


\textsuperscript{22} Swisher, L. L. (2002), p 702.
routinely encounter. Her conclusion as to the nature and direction of future research is that it should be guided by a multi-dimensional framework incorporating:\(^{23}\)

1. patient perspectives on ethical issues in physiotherapy;
2. variety in ethical approaches;
3. factors affecting ethical judgment, sensitivity, motivation and courage; and
4. cultural dimensions of ethical practice.

My review of the physiotherapy ethics literature is more narrowly focussed than the review by Swisher. My analysis and categorisation of the literature involves an examination of what Swisher refers to as ethical sensitivity (recognising and interpreting situations) and ethical judgement (making a decision about right or wrong and determining a course of action),\(^ {24}\) as they relate to the ethical theory of autonomy and the process of obtaining informed consent. I begin with definitions of informed consent taken from the physiotherapy literature and then I discuss the way the literature has incorporated ethical notions of autonomy into the practical ways of understanding and implementing informed consent.

**The relationship between informed consent and the ethical theory of autonomy**

Four definitions of informed consent taken from the physiotherapy literature illustrate the evolving approach over time to informed consent within the profession. The first two focus on procedures to follow and elements that make up informed consent. The second two suggest the need for a broader view of it as a process, with implications for all areas of clinical practice:

**Definition 1**

Informed consent is the voluntary and revocable agreement for competent individuals to participate in a therapeutic or research procedure, based on an understanding of its nature, purpose and implications.\(^ {25}\)

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\(^{25}\) Sim, J. (1986), p 584.
Definition 2

Informed consent spells out how the health professional intends to use specific diagnostic or treatment techniques for the purpose of improving a patient’s condition. 26

Definition 3

Informed consent becomes a process that underlies the patient-health care professional relationship - an ongoing dialogue between the patient and the health care provider, not merely a single dateable event that occurs whenever a decision must be made because potentially harmful consequences. 27

Definition 4

Informed consent is a collaborative, truth telling process that requires a high degree of emotional maturity on the part of healthcare professionals. 28

Tables 4-(1-3) provide an overview of the physiotherapy literature which has explicitly focused on autonomy and/or informed consent. In this chapter, table 4-1 appears below, 4-2 on p.117 and 4-3 on p.118. In each of the tables I have categorised the papers according to whether the authors predominantly discuss:

1. why informed consent is significant and what elements are emphasised;

2. what ethical principle underlies informed consent; and

3. how autonomy as an underlying ethical principle could or should impact on the practice of obtaining informed consent.

### Table 4-1: Why informed consent is significant

<table>
<thead>
<tr>
<th>Date</th>
<th>Author</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>Ramsden, E.</td>
<td>The Patient's Right to Know[^29]</td>
</tr>
<tr>
<td>1982</td>
<td>Warren, M.</td>
<td>Personal ethical responsibility[^31]</td>
</tr>
<tr>
<td>1984</td>
<td>Purtilo, R. B.</td>
<td>Applying the Principles of Informed Consent to Patient-Care - Legal and Ethical Considerations for Physical Therapy[^12]</td>
</tr>
<tr>
<td>1986</td>
<td>Sim, J.</td>
<td>Informed consent: ethical implications for physiotherapy[^33]</td>
</tr>
<tr>
<td>1987</td>
<td>Banja, J. D. and S. L. Wolf.</td>
<td>Malpractice litigation for uninformed consent: implications for physical therapists[^34]</td>
</tr>
<tr>
<td>1988</td>
<td>APA</td>
<td>Protocol for pre-manipulative testing of the cervical spine[^35]</td>
</tr>
<tr>
<td>1994</td>
<td>Sim, J.</td>
<td>Advising patients on claims for negligence[^36]</td>
</tr>
<tr>
<td>1996</td>
<td>Delany, C.</td>
<td>Should I warn the patient first?[^37]</td>
</tr>
<tr>
<td>1996</td>
<td>Vines, P.</td>
<td>Informed consent: From paternal benevolence to trust mediated by truthfulness[^38]</td>
</tr>
<tr>
<td>1996</td>
<td>Triezenberg, H. L.</td>
<td>The identification of ethical issues in physical therapy practice - Response[^39]</td>
</tr>
<tr>
<td>1997</td>
<td>Scott, R.</td>
<td>The Patient Self Determination Act of 1990: are Health Care Providers meeting their Legal Duty owed to Patients?[^40]</td>
</tr>
<tr>
<td>2001</td>
<td>Barker et al.</td>
<td>Guidance for pre-manipulative testing of the cervical spine[^44]</td>
</tr>
<tr>
<td>2001</td>
<td>Elkin, S.</td>
<td>Informed consent: Requirements for legal and ethical practice. Physiotherapy &amp; Practice[^45]</td>
</tr>
<tr>
<td>2002</td>
<td>Delany, C.</td>
<td>Cervical manipulation-how might informed consent be obtained before treatment?[^46]</td>
</tr>
<tr>
<td>2002</td>
<td>Kerry, R.</td>
<td>Pre-manipulative Procedures for the Cervical Spine[^47]</td>
</tr>
<tr>
<td>2002</td>
<td>Swisher</td>
<td>A retrospective analysis of ethics knowledge in physical therapy (1970-2000).[^48]</td>
</tr>
</tbody>
</table>

[^29]: *Physical Therapy, 55*(2), 133-138.
[^30]: *Physical Therapy, 60*(10), 1264-1272.
[^31]: *Physiotherapy, 68*, 355-356.
[^32]: *Physical Therapy, 64*(6), 934-937.
[^33]: *Physiotherapy, 72*(12), 584-586.
[^34]: *Physical therapy, 67*, 1226-1229.
[^36]: *Physiotherapy, 80*(9), 619-620.
[^39]: *Physical Therapy, 76*(10), 1097-1107.
[^46]: *Journal of Law and Medicine, 10*(2), 174-186.
The division of the papers in tables 4-(1-3) according to their interest in informed consent highlights a sporadic and uneven development of the literature in this area, a situation which has significant parallels to the medical profession. However, it demonstrates that unlike the medical literature, the physiotherapy profession has not developed or discussed the implementation of models of practice that explicitly link the ethical theory of autonomy to the process of obtaining informed consent in clinical practice. In other words, whilst the literature highlights ethical sensitivity to informed consent, it displays gaps in discussion of ethical judgement or the ethical basis underpinning the implementation of informed consent.

Why has informed consent been recognised (Table 4-1)

Sensitivity to and awareness of informed consent has arisen from a number of different sources in the physiotherapy literature. It has been identified as a significant ethical and legal issue in the physiotherapy ethical discourse,\(^{49}\) in physiotherapy research,\(^{50}\) in the development of autonomous professional status,\(^{51}\) because of changes in the law,\(^{52}\) and for particular high risk physiotherapy treatments.\(^{53}\)

The most common response in the physiotherapy ethics literature as to why informed consent is significant for physiotherapists has been to stipulate that obtaining patients’ informed consent is an ethical and legal duty with which therapists are expected to comply.\(^{54}\) An example of how informed consent has been stipulated as a legal duty is the paper by Banja and Wolf where the authors state:\(^{55}\)

As a professional group that puts patients at risk of harm during treatment, physical therapists need to know about their legal duty to facilitate a patient’s awareness and consent to treatment.

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\(^{48}\) *Physical Therapy, 82*(7), 692-706.


\(^{50}\) Warren, M. (1982).


Chapter 4 – Informed consent: physiotherapy literature

The concern of these authors is to alert therapists to the requirements of the law and to provide strategies for reducing ‘the likelihood of a malpractice action alleging non-disclosure of risks of, or consequences from physical therapy’. They advocate the use of a ‘description of treatment form’ and a ‘risk check list’ that could be discussed and signed by both the therapist and patient before commencing therapy.

In an earlier paper, Purtilo gives broader reasons for the significance of informed consent. She contends that therapists should be cognisant of legal concepts of self determination in addition to moral duties to protect patients’ moral rights to self determination. However, her suggestions as to why and how therapists should therefore implement the informed consent process do not correspond to these broader ethical frameworks. Instead, she directs attention to the likely effect of obtaining informed consent upon the therapeutic outcome and its potential to increase trust between therapist and patient. In Purtilo’s discussion of informed consent, a person’s actual capacity, in terms of their freedom to make or ability to reason about autonomous decisions, is defined narrowly as the idea of competence or incompetence to make a rational decision at the time. In this paper, Purtilo emphasises two elements of informed consent: disclosure of information and obtaining consent:

At the very least, physical therapists who wish to uphold high ethical standards in their practice should be diligent in providing (orally) pertinent information to the patient about the purpose, rationale and expected consequences of alternative courses of action and to solicit the patients’ informed opinions.

Sim defines the elements of informed consent more broadly than Purtilo. According to Sim, the elements encompass disclosure, comprehension, competence and voluntariness. He suggests that the fiduciary nature of the therapist/patient relationship and the fact that the patient is in a position of needing to trust the therapist means the therapist ‘should take special

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60 Sim, J. (1986), p 585.
pains to explain the nature of the course of treatment proposed, and not take the patient’s voluntariness of consent for granted’. 62

Building on the ideas of both Sim and Purtilo, Elkin also suggests further reasons for why informed consent is significant for physiotherapists. Her contention is that the law has had a restrictive role in guiding the process of informed consent with its main concern being patient competence to consent and prevention of harm and its establishment of minimum requirements relating to gaining a ‘legally binding informed consent’. 63 Whilst Elkin refers to the law’s relative disinterest with exploring a broader meaning of patient autonomy, she does not explore how the ethical meaning of autonomy might change the informed consent process other than to say that it should inform the process.

Notwithstanding that the authors discussed above have all posited broader ethically based reasons for considering the significance of informed consent, the more common focus in the literature has been on the importance of disclosure of information and the type of consent which is necessary for compliance with legal obligations of informed consent. A good example of this focus on actions for compliance, rather than guidance as to reflection about the need for such action, is found in both the original protocol and revised guidelines developed by the Australian Physiotherapy Association (APA) to guide the clinical implementation of informed consent.

In 1988 the APA formalised a protocol or clinical standard for pre-manipulative testing of the cervical spine. The stated intention of the protocol was ‘to ensure that physiotherapists use responsibly the effective manipulative techniques at their disposal’. 64 The protocol provides information about clinical screening procedures to identify risk factors associated with cervical manipulation. The screening tests were aimed at providing adequate clinical information to the therapist to ensure that they performed cervical manipulation safely and effectively. In the section which discussed the necessary communication to consider in order to obtain patients’ informed consent to this type of treatment, the protocol stated

At law it is essential that the patient understands the manipulative procedures that you wish to undertake and its associated dangers. 65

The protocol provided examples of wording to use prior to manipulation:

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63 Elkin, S. (2001), p 104
64 Australian Physiotherapy Association (1988), p 97.
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 necessary precautionary tests and in my opinion there is little risk in your case. Are you agreeable for me to go ahead?

In 1988 the language of the protocol was consistent with then current Australian law. It also reflected a style of ethical guidance which was prescriptive in approach and framed the ethical obligation to obtain informed consent as a bio-medical and beneficent clinical judgment to be made. The basis of the protocol was a need to comply with the law by using responsible ‘physiotherapist-determined’ clinical reasoning techniques. The guidelines reflect the role of the therapist as the person having the responsibility for making clinical decisions.

In a 1996 critique of these guidelines I relied upon a more in depth examination of current legal requirements, including the shift in the law’s focus requiring the physiotherapist to ‘tailor the advice to the particular needs, personality and circumstances of the patient’. This 1996 contribution to the literature, whilst adding depth of knowledge to the legal obligation, nevertheless conformed to the ‘compliance with duties and rules’ approach to ethical action.

When revised guidelines were published by the APA in 2000 there was a shift towards acknowledging the needs of the patient, particularly in the consent section of the guidelines. The components of obtaining informed consent were separated and expanded in the 2000 APA guidelines into two elements of provision of information and gaining consent. Section 4.1 of the guidelines concerns the provision of information and states:

- It is essential that physiotherapists provide patients with information about procedures to be used in treatment, in particular, manipulative techniques.

- Information may be provided orally by the physiotherapist or in an information sheet/brochure, to ensure that the information is standardised, in the initial instance. Such information, whether delivered orally or in a brochure, must cover the following:
  - information about the procedure
  - alternatives to the proposed treatment
  - benefits and risks of the proposed procedure

66 The law prior to Rogers v Whitaker in Australia relied upon the expertise of the treating practitioner as a basis for providing information and treatment. This has been referred to in chapter two, as the Bolam principle.


- the opportunity to ask questions
- the opportunity for the patient to change his/her mind during the procedure (where practical)
- the opportunity for the patient to take time to reflect on the information provided before agreeing to the procedure.

Section 4.3 concerns the processes of gaining consent. It emphasises how the physiotherapist should comply with the obligations of providing information. It states:

• Information must be provided to the patient in a form that is understandable by the patient, whether orally or by means of an information brochure, as outlined above.
• The physiotherapist has a responsibility to ensure that the patient understands the information provided.
• The patient must be given the opportunity to ask questions about a particular procedure.
• The physiotherapist may then ask for consent to proceed. As indicated above, consent is only valid if it is given freely and with an adequate degree of understanding of what the procedure entails.

Section 4.2 of the 2000 APA guidelines provides definitions of ‘express’, ‘implied’ and ‘tacit’ consent. It suggests that express consent (explicit agreement orally or in writing) is required for cervical spine manipulation, whereas implied consent (non-specific agreement, but some action which suggests consent) is acceptable for non-manipulative procedures of the cervical spine.

Although the 2000 guidelines clearly expanded the section on how to obtain informed consent in practice, further commentary on the APA guidelines acknowledged continued uncertainties confronting the clinician seeking to reliably predict risk factors in patients prior to manipulation. Concerns included the use of screening tests that have inherent reliability, validity (and safety) limitations, the difficulty of identifying with accuracy the real risk of manipulation (including the various methods of application), and the relative risk of mobilisation treatment without manipulation. Concern was also expressed as to the effect on legal liability of following or not following the APA guidelines.

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These arguments reflect concerns which in effect are similar to what one author terms a ‘legal flak jacket’ response. That is, therapists were more concerned with how the protective armoury of evidence-based clinical efficacy and appropriate educational qualifications would protect them from any legal threat.

Whilst the revised guidelines more explicitly incorporate the individual needs of the patient, commentaries and responses by the profession demonstrate that informed consent is considered to be significant because it potentially results in safe clinical practices. These include the importance of avoiding medicolegal risk. They are guidelines for action and procedural compliance. In that sense they are similar to features of the action-based models of informed consent discussed in the previous chapter. They are not guidelines for reflection because they do not define or link the meaning of autonomy as a way of providing guidance for the action of obtaining a patient’s informed consent to treatment. Taking the iceberg model, the guidelines neither require nor direct the therapist to look below the surface of the water.

In chapter two I suggested that a reliance on the visible elements of informed consent as the dominant guide for the process in clinical practice may result in a superficial and somewhat inflexible response given the depth of meaning of the underlying ethical theory of autonomy. The initial 1988 APA protocol and the 2000 revised guidelines on informed consent have focussed on the validity of risk factors of the treatment, the actual risk of treatment and legal liability. That is, the focus has been limited to the duty to obtain consent as it relates to one particular treatment. In the next section, I highlight those authors (table 4-2) who have widened the interest in the ethical idea of autonomy as it underpins the duty to obtain patients’ informed consent.

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73 Jones, M. A. (1999), p 134. Like Brody’s transparency model, the guidelines provide guidance about what information to give and, like Wear’s event model the guidelines delineate the particular treatment for which informed consent is necessary.
What ethical principle underlies informed consent (Table 4-2)

Table 4-2: What ethical principle underlies informed consent

<table>
<thead>
<tr>
<th>Date</th>
<th>Author</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>Clawson, A. L.</td>
<td>The relationship between clinical decision-making and ethical decision-making(^74)</td>
</tr>
<tr>
<td>2003</td>
<td>Delany, C.</td>
<td>Editorial: Informed consent: Broadening the focus(^75)</td>
</tr>
<tr>
<td>1996</td>
<td>Sim, J.</td>
<td>Professional issues: informed consent and manual therapy(^76)</td>
</tr>
<tr>
<td>1996</td>
<td>Vines, P.</td>
<td>Informed consent: from truthful benevolence to trust mediated by truthfulness (^77)</td>
</tr>
</tbody>
</table>

In comparison to the papers listed in table 4-1 and discussed above, the papers listed in table 4-2 have more explicitly linked the communicative actions of the physiotherapist in obtaining a patient’s informed consent to the principle of autonomy. Whilst that is so, the implications of such a connection are discussed mostly in terms of procedural compliance with the ethical principle of autonomy stated to underlie the requirement for informed consent. For example, whilst Clawson states that the issue of informed consent is directly related to the issue of patient autonomy,\(^78\) her definition of autonomy in the context of physiotherapy care is expressed in the form of four ethical exhortations, as follows:\(^79\)

1. Patients must be included in the decision-making process
2. Physiotherapists must be knowledgeable about benefits and risks of treatment alternatives
3. Patients must be allowed to refuse treatment that they do not desire
4. Treatment plans and treatment goals should be the product of joint decision-making between therapists and informed patients.

The underlying ethical premise of what autonomy means and why it is ethically important in physiotherapy treatment is not explored. In a similar way, Sim\(^80\) seeks to broaden the definition and reason for obtaining informed consent beyond ‘helping to protect the manual

\(^74\) Physiotherapy, 80(1), 10–14.
\(^75\) Australian Journal of Physiotherapy, 49(3), 159-161.
\(^76\) Journal of Manual Therapy, 1(2), 104-106.
\(^77\) Australian Journal of Physiotherapy, 42(3), 245-246.
therapist from unwanted litigation’ to the ‘less tangible but equally important ethical implications of informed consent’.

Although Sim refers to autonomy as providing the underlying ethical support for informed consent in manual therapy, he also stops short of defining the ethical meaning of autonomy as a source of guidance for informed consent. Instead he states:

According to this principle [of autonomy], individuals should be permitted to decide for themselves what actions they wish to take and what should happen to them at the hands of others.

I have included reference in table 4-2 to an editorial which I wrote in 2003 in which I aimed to broaden the understanding and discussion of informed consent. I suggested that an understanding of autonomy as the underlying principle supporting informed consent would not only meet legal obligations but also would be more likely to meet the individual needs and values of patients. Although I called for a broader view of the elements of informed consent to encompass the ethical ideal of patient autonomy, like the other authors in table 4-2, I stopped short of defining the ethical meaning of autonomy. Authors in table 4-3 as the heading suggests, begin the process of unpacking the meaning of autonomy as an underlying principle for the process of informed consent.

*How does the ethical theory of autonomy influence the practice of obtaining informed consent (Table 4-3)*

**Table 4-3: How autonomy should influence informed consent**

<table>
<thead>
<tr>
<th>Date</th>
<th>Author</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>Coy, J.</td>
<td>Autonomy-based informed consent: ethical implications for patient non-compliance&lt;sup&gt;83&lt;/sup&gt;</td>
</tr>
<tr>
<td>1996</td>
<td>Haswell, K.</td>
<td>Informed choice and consent for cervical spine manipulation&lt;sup&gt;84&lt;/sup&gt;</td>
</tr>
<tr>
<td>1998</td>
<td>Sim, J.</td>
<td>Respect for autonomy: issues in neurological rehabilitation&lt;sup&gt;85&lt;/sup&gt;</td>
</tr>
<tr>
<td>2005</td>
<td>Delany, C.</td>
<td>Respecting patient autonomy and obtaining their informed consent: Ethical theory - Missing in action.&lt;sup&gt;86&lt;/sup&gt;</td>
</tr>
</tbody>
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<sup>81</sup> Sim, J. (1996), p 106.
<sup>82</sup> Sim, J. (1996), p 104.
<sup>83</sup> *Physical Therapy*, 69(10), 826-833.
<sup>84</sup> *Australian Journal of Physiotherapy*, 42(2), 149-155.
<sup>85</sup> *Clinical Rehabilitation*, 12(2), 3-10.
<sup>86</sup> *Physiotherapy*, In press.
The least developed response in the physiotherapy literature is a discussion of the meaning of the underlying ethical principle of autonomy as a way of defining the practical action of obtaining informed consent. The four authors listed in table 4-3 fit this category, although they do not advance the discussion to an explicit model of thinking or acting based on the underlying ethical theory.

The paradigm article is by Coy, where the author aimed to demonstrate the value of understanding the moral meaning of autonomy as a basis of action for informed consent. Coy refers to the following description of the principle of autonomy from Gorovitz:

Autonomy is]…the view that individuals are entitled to be and do as they see fit, so long as they do not violate the comparable rights of others. No person is to be merely the instrument of another person’s plans; no person is to be treated in a manner that is blind to the plans, desires, and values that are the fabric of his or her life and identity. Roughly speaking, we believe that it is obligatory to leave people alone, unless we have powerful reasons for not doing so.

Coy maintains that when this meaning of autonomy is applied as an underlying reason for obtaining informed consent it expands the situations in which informed consent becomes an important issue. Coy’s main argument is that if respect for autonomy forms the underlying reason for providing information, ensuring voluntariness and obtaining a patient’s consent, then the patient’s actual decision is less important than the fact that they were given an opportunity to make a decision. According to Coy, informed consent based on this ethical meaning of autonomy implies that it will be required:

…not only for interventions that have potentially harmful consequences but also for many other types of procedures or treatments, including physical therapy, that are generally perceived to be harmless or low harm and low risk procedures.

Sim and Haswell build on Coy’s discussion in the specific areas of rehabilitation (Sim) and manual therapy (Haswell). According to these authors the definition of informed consent should include the significance and role of autonomy rather than being confined to the procedural elements of information disclosure and consent contained in the definitions

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discussed earlier in this chapter. Haswell explicitly rejects reliance on the elements of informed consent for defensive legal purposes by stating that:

In a limited interpretation, informed consent is perceived as merely a legal formality designed to protect the physiotherapist from medical misadventure claims. \(^{91}\)

Instead, she adopts Coy’s term of ‘autonomy enhanced informed consent’ because of the fact that it considers both legal and moral perspectives and its goal is directed towards enabling patients to make important decisions regarding their health, rather than protecting the therapist from litigation.

Sim also refers to Coy’s idea of autonomy being central to informed consent. \(^{92}\) He draws on Gillon’s definition of autonomy as ‘the capacity to think, decide and act on the basis of such thought and decisions freely and independently.’ \(^{93}\) Sim uses this definition to frame the obligation to respect and enhance patients’ participation in decision-making and suggests that health professionals need to both preserve and enhance the capacities of patients to exercise such self determination. \(^{94}\)

Sim’s explanation of how respect for autonomy might impact in clinical practice echoes the ideas of Emanuel and Emanuel’s interpretive and, to a lesser extent, deliberative model. He suggests that practitioners should ensure that their skill and expertise in determining the best treatment for a given therapeutic outcome remains separate from the patient’s ultimate choice as to whether the treatment outcome is suitable or not. Sim contends that therapists should not assume that their values and treatment goals are the same as their patients. \(^{95}\) Unlike previous authors, in particular those in table 1, Sim emphasises the element of voluntariness and uses knowledge of potential barriers to and methods of enhancing a patient’s voluntary participation as factors to consider when framing the information to be disclosed. He states that:

in order to allow autonomous choice on the part of the patient, the patient needs to be aware not only of the content of the information given, but also the manner in which it is conveyed, which may imply to the patient less scope for refusal than the practitioner intends. \(^{96}\)

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\(^{92}\) Sim, J. (1998).


Although Sim does not explicitly refer to ethical theories of autonomy his discussion encompasses what Katz has described as a patient’s ‘internal’ capacities and values and ‘external’ opportunities for participating autonomously. Each of the authors, Coy, Haswell and Sim refer to informed consent which is underpinned by the ethical theory of autonomy as ‘autonomy based informed consent’. This conception of informed consent provides a broader based framework for understanding and implementing informed consent in practice. However, I contend that it is not the same as the concept of ‘ethically-enriched’ informed consent, developed in the preceding two chapters.

‘Ethically enriched’ informed consent means actively incorporating ideas of autonomy and not just stating that autonomy should underpin the action. It includes thinking about how a clinical context and clinical purpose might affect a patient’s capacities for reasoning and ability or opportunity to reflect about their short and long term therapeutic and well-being interests. It means altering both the content of communication and the goals of the communication.

So far in my review of the physiotherapy ethical discourse, I have highlighted how physiotherapy authors have described why informed consent is significant and how they have linked the ethical theory of autonomy to the process of informed consent. Importantly, I have demonstrated that the relationship between autonomy and informed consent has not been explored in depth. Whilst the studies listed in tables 4-(1-3) have discussed the element of informed consent and the underlying ethical theory, there have been very few studies that have examined how physiotherapists go about obtaining informed consent in practice. In the next section, I examine these studies.

**Empirical studies of informed consent in physiotherapy practice**

In the previous two chapters I noted how in the area of medical practice, informed consent owes its genesis not so much to an extension of the already existing goals of medicine, but rather, as a reaction to the imposition of law and the requirement for professional accountability. The physiotherapy literature, particularly the focus of the empirical investigation of informed consent also reflects this reactive response. The only studies to directly examine informed consent in the clinical setting have been concerned with measuring compliance with the APA protocol concerning informed consent in cervical manipulation discussed above in association with table 4-1.
One of the first reviews of how physiotherapists understood and implemented the original APA protocol to obtain patients’ informed consent was a 1988 questionnaire. It found a high level of compliance with the physical screening procedures advocated by the protocol. Less compliance was found in the area of physiotherapists obtaining informed consent, specifically by use of the protocol-suggested wording. Many responding felt that the requirement of informed consent on the part of the patient would mean fewer patients would agree to manipulation as a form of treatment, and this valuable method of treatment would therefore be used less frequently.

As part of the 2000 review of the APA guidelines, a further survey was undertaken about physiotherapists’ use of the then current 1988 guidelines. According to this survey of physiotherapists with postgraduate training in manipulative therapy, compliance with the protocol of screening and gaining informed consent was poor. Many of the manipulative therapists surveyed thought that the protocol requiring objective screening of patients was cumbersome, and despite recognition by respondents of the legal necessity, many acknowledged a failure to comply with the need to obtain informed consent to treatment.

These studies demonstrate some uncertainty and reluctance on the part of practitioners as to their view of the desirability and value of the process of informed consent and the advocated methods of clinical communication. In the next section I broaden the focus from studies that focus on the process of informed consent to examine what is known about clinical communication in more general terms.

**Empirical studies of physiotherapy communication**

The process of informed consent is a process of communication. In the previous chapter I demonstrated that practical implementation of different models of informed consent resulted in different features of the informed consent process. The features consisted of differences in content and differences in style of communication. My aim in the section below is to review what is known about the features of physiotherapy communication, as a prelude to my empirical examination of informed consent occurring within clinical communicative practices.

Studies of physiotherapy communication have involved both direct and indirect investigation of physiotherapists’ communicative actions and related knowledge and attitudes. Although

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these studies have not set out to study how the informed consent process occurs in practice, or how the ethical concept of autonomy is incorporated into the action of obtaining informed consent, they do provide an insight into the aims and focus of physiotherapy communication. The studies have examined differences in communicative practices and goals of communication from a range of perspectives. They include a comparison of communicative practices between expert and novice therapists, the educative content of therapists’ communication, the influence of methods of communication on the patient/therapist relationship and the effect of communication on the treatment outcome. The picture they provide about physiotherapy communication is one of communication which is oriented towards a defined clinical goal and initiated and controlled by the therapist.

Several studies have illustrated the significance of patient education as a goal of physiotherapy communicative practice. For example, Sluijs audio-taped physiotherapy treatments and measured the amount of patient education that therapists provided in each treatment session. Two hundred and twenty-seven treatment sessions were analysed and Sluijs found that some kind of patient education was included in eighty-five percent of these sessions. Importantly, Sluijs noted that the amount of patient education was unplanned and usually occurred early in a series of treatments. In this study, therapists formulated the educational content of the communication according to clinical aims of treatment, and seldom asked patients to discuss their perceptions of the problem.

Jensen et al. distinguished professional attribute dimensions between master and novice physiotherapists and found that experience or expertise also impacted on therapists’ use of education as a valued component of communication. The master clinicians described teaching (including teaching patients to assume responsibility for their own health care) as one of their most important clinical skills, whereas the novice clinicians identified patient rapport and hands-on skills as more important treatment skills.

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There a number of physiotherapy studies that have examined the communication between a physiotherapist and their patient to assess the style of the communication, the goals of the communication and their potential effect on patients and treatment outcomes. What is evident in these studies is that therapists tend to rely upon formal and biomedical models of practice and that the predominant goal of physiotherapy practice is to provide a physical or functional benefit to the patient. A recurring theme from these studies is that therapists did not readily enquire about patients’ values, goals and thoughts.

In a study of therapists with postgraduate training in manipulative therapy, Haswell identified basic interviewing skills used by 14 physiotherapists during the interview component of the initial assessment. Six basic interviewing skills were identified from the transcripts of the interviews: closed enquiry, open enquiry, minimal encouragement, paraphrasing, giving information and giving opinion. Closed questions scored the highest percentage value within the range of identified interviewing skills, which suggests an interest in clinical information rather than an interest in broader patient interests, values and goals.

Thornquist studied the interaction in first encounters between patients and physiotherapists in Norway by video observation and interview of the physiotherapist. The purpose of this study was to examine how physiotherapists relate to and examine patients. Thornquist found that therapists controlled both the content and form of the dialogues so that the patients’ own versions were allowed little place. In particular, during the clinical examination, Thornquist found that ‘the therapists narrowed down their diagnostic interest to local conditions and interpreted local findings within a biomechanical frame of reference’.

What is apparent in this study and in several studies below, is that although therapists were aware of the potential influence of patients’ values, goals and beliefs within treatments, they did not explicitly acknowledge this awareness or broader understanding to the patient.

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Talvitie and Reunanen investigated dominant forms of interaction between physiotherapists and patients in the treatment of strokes, by the use of discourse analysis. They found that the physiotherapists hardly ever talked to patients about the goals of therapy, and these patients were allowed little opportunity to take the initiative in their treatments. In an earlier study, Talvitie studied the ways in which five physiotherapists in Finland provided their patients with information pertaining to a therapeutic action or exercise to be performed. The results showed that although the physiotherapists made extensive use of verbal and manual guidance, the main means of instruction was a request to assume the correct position for the next exercise. In other words, the therapists hardly ever discussed in collaboration with the patient, the goal of the therapy or the importance of the exercise in the context of the rehabilitation programme.

Parry also examined the nature of goal setting within clinical communication. She used conversation analysis to analyse the communication practices of therapists and patients during physiotherapy goal-setting in stroke rehabilitation settings and found:

In most goal-setting episodes, patients’ participation and contribution was limited in that the target problems or abilities were ‘supplied’ by therapists rather than elicited from patients, whose verbal contributions were often limited to brief answers to therapists’ proposals.

Gyllensten et al. examined Swedish physiotherapists’ perceptions of important factors influencing the process of interaction between patient and therapist. In this study, the authors found that expert practitioners were concerned to achieve a constructive dialogue with ‘empathy, respect, engagement, sensitivity and the ability to listen,’ seen as vital tools to the interaction. Significantly, therapists’ motivations for using these communication tools were related to their effect on enhancing patient responsibilities for their own health and as a way of achieving a better outcome.

A dominant theme to arise from these different perspectives of therapists’ clinical communication is that therapists tend to be goal oriented and focussed on the achievement of a therapeutic outcome. A strong focus of therapists’ communication within the studied interactions was on physical outcomes, and not on connections with ethical theory or the

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effects of the communication on patients’ abilities and opportunities to give their informed consent. Whilst the communication studies did not set out to examine the link between communication and ethical obligations, when their findings are examined through ‘an ethical interest’ lens, they suggest that the ethical ideal of benefiting the patient is a consistent underlying value driving clinical communication. In the next section I discuss recent studies which combine an interest in both ethical knowledge and ways of communicating.

**Examination of ethical reasoning**

There have been a number of empirically based papers examining how therapists describe and interpret ethical situations and what processes are used in their decisions about ethical issues. These studies have identified sources and types of ethical issues encountered by physiotherapists and associated sources and methods of reasoning. In this literature, more explicit links have been made between processes of clinical communication and the incorporation of ethical ideals. Whilst these studies have not been primarily concerned with autonomy and informed consent, their exploration of the place of ethical reasoning is important to highlight prior to my examination of how ethical values underlying informed consent are translated into practice.

Barnitt and Partridge compared the framing and recognition of ethical dilemmas between physiotherapists and occupational therapists. These authors found that the overall frame of reference adopted by physiotherapists in describing a clinical situation as an ethical dilemma was a biomedical and cognitive one. This was in contrast to the psychosocial and humanistic frame of reference adopted by occupational therapists. In their study, the ethical dilemmas identified by the physiotherapists were thematically categorised as ‘challenges to professional judgments by patients, carers and other professionals,’ ‘difficult patients or carers’ and ‘therapists’ observation of poor or dangerous treatment’. In contrast, the occupational therapists identified communication difficulties particularly in hierarchical workplaces and problems associated with working with limited support in the community.

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115 Barnitt, R., & Partridge, C. (1997), p 193. As a reason for this, the authors note that in their training, physiotherapists major in the biomedical domain with a grounding in the psychosocial domain, while occupational therapists major in psychology and have a grounding in biomedicine.

I suggest that one interpretation of these findings is that physiotherapists identified an ethical dilemma according to its effect on their ability to get their work done in a safe and effective manner. Other studies of the ethos of professional physiotherapy practice support this type of professional outlook and commitment to achieving results. For example Roberts noted a strong practice belief by physiotherapists in identifying a specific etiology or cause for an illness. Related to this idea of definitive treatments and causes, Cromie et al. found that therapists’ underlying views of a ‘right’ way to perform tasks was central to their expressed values of being knowledgeable and capable. Stiller argued that one of the most enduring traits of physical therapists in the United States was ‘the premium that physical therapists put on caring, on helping people to be the best they can be.’ This body of research has not linked the ethos and underlying values of clinical practice to the ways of understanding and processes of implementing informed consent within clinical communication. However the research suggests that therapists are more explicitly task oriented and committed to achieving results than to interpreting or questioning the role and meaning of ethical obligations within their practice.

Jensen and et al. used a different comparative lens to examine physiotherapy practice. They examined the attribute dimensions of expert physiotherapists in the United States to develop a theoretical model of expert practice. These authors identified several moral virtues in the expert physiotherapy practitioners they studied. They included a strong inner drive to succeed and continue to learn, to have the patient’s best interests in mind and an orientation to solve the problems of and not judge patients. The authors claimed that these virtues in combination with a process of collaboration between therapist and patient provided evidence of a type of ‘expertise in professional virtues’.

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118 Cromie, J., Robertson, V., & Best, M. (2002). Work-Related Musculoskeletal Disorders and the Culture of Physical Therapy. Physical Therapy, 82(5), 459-472. In this study therapists’ views were based on their personal experiences of work related musculoskeletal disorders.
119 Stiller, C. (2000). Exploring the ethos of the Physical Therapy Profession in the United States: Social, Cultural, and Historical Influences and Their Relationship to Education. Journal of physical therapy education, 14(3), p 9. Other enduring traits identified by Stiller were ‘hard work and dedication,’ ‘warmth and openness’ and ‘a positive attitude.’
Eaton et al. built on this work by further exploring the descriptions and interpretations of ethical situations by experienced and novice physiotherapists. They reported that novice physiotherapists sometimes struggled with tensions within their professional duty and tended to be more rule driven and reliant on the American Association Code of Ethics. In contrast, the more experienced practitioners used gut instinct and common sense to influence their ethical decision-making. According to these authors, the more expert practitioners had an acute and inbuilt awareness of levels of accountability in the health system and their position within it.

These studies illustrate a type of professional ethical stance which values therapeutic achievement aligned with patients’ best interests. The idea of beneficence as an ethical ideal, expressed as doing the best by the patient, is a strong underlying value guiding ethical reasoning.

Building on Jensen’s work, Edwards et al. qualitatively examined physiotherapists’ strategies of clinical and ethical reasoning. Based on their research of therapists working in different areas of clinical practice, Edwards et al. found that therapists’ clinical and ethical reasoning draws from several sources and results in a combination of different reasoning processes: diagnostic, procedural, narrative, interactive and ethical reasoning. As a consequence, they concluded that within clinical physiotherapy practice

Ethical reasoning is multi-dimensional and incorporates the use of ethical principles, recognition of cases and understanding the perspectives of those involved in a dilemma.

These authors suggest that the process of ethical reasoning ‘could’ and ‘should’ be integrated into wider clinical-reasoning frameworks. They use examples of therapists’ decision-making in practical situations involving ethical issues to demonstrate how the process of making ethical decisions is similar to the process of making clinical decisions. The authors describe two types of ethical decision-making used by therapists. The first is a deductive process where the therapist moves from ethical theory through rules and principles to ethical judgment in a clinical situation. The second is a narrative process where the patient’s story or narrative guides the therapist’s ethical reasoning. Importantly the authors argue that these two process are similar to the dialectical nature of clinical reasoning which they had previously defined as

‘reasoning that moves between those cognitive and decision-making processes required to optimally diagnose and manage patient presentations’ and ‘those required to understand and engage with patients’.

Based on these similarities, Edwards et al. suggest that ethical reasoning may be regarded in a similar manner to ‘other areas of reasoning and decision-making in physiotherapy practice,’ and as a consequence, ‘remain as comprehensive and rigorous as possible.’

The literature concerned with clinical reasoning has focused on the steps involved in and factors affecting the processes of clinical decision-making. In the same way, the significant area of interest in the studies of ethical reasoning has been on the processes of ethical decision-making, and the factors that influence therapists in that reasoning. The studies do not explore the underlying ethical values that are brought to the clinical encounter through the process of ethical reasoning. Edwards et al. explicitly acknowledge in their paper linking ethical reasoning to clinical reasoning strategies that they do not address ‘philosophical ethical theories per se’ but state that:

An understanding of these [philosophical theories] is important for the ethical reasoner to draw upon just as a background knowledge of anatomy and physiology etc. is important in decision-making in clinical practice but is not in itself sufficient for good decision-making.

In the growing body of physiotherapy literature that is concerned with ethical reasoning, the place of ethical theory or the ethical value being expressed is recognized as one component of the reasoning process. Van Hooft et al. describe ethical reasoning as a process of moving from a premise or expression of an ethical value through a process of reasoning to reach an ethical conclusion. The way ethical decisions are characterised in the studies discussed above is in terms of what combination of thought processes have occurred to reach a considered and reflective decision, rather than what type of ethical value is being relied upon to inform the ethical reasoning process.

My interest in this research is not directly on what processes of reasoning a therapist is using when they obtain a patients’ informed consent. Instead I examine therapists’ understanding of the underlying ethical premise of autonomy and how that premise is interpreted as an ethical value within the context of clinical communication and the process of informed consent.

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Summary of chapter four

In this chapter I have traced the development and content of the physiotherapy ethical discourse as it relates to autonomy and informed consent from two main perspectives. The first concerned how the ethical theory of autonomy has been linked to the process of informed consent in the physiotherapy ethical literature. I found that whilst there have been repeated calls for greater recognition and understanding of ethical issues for physiotherapists since the 1970s,\textsuperscript{129} and empirical evidence that informed consent presents as a thorny or difficult issue for practitioners,\textsuperscript{130} there has been little unpacking of ethical theories in general. This applies in particular to the moral theory of autonomy as it underlies the clinical practice of obtaining patients’ informed consent to treatment. As a consequence, unlike the medical profession, there are no models of practice of informed consent designed to link the theory of autonomy to its implementation in the process of informed consent.

In their development of ethical obligations and principles of ethical practice, physiotherapists have relied upon medical ethical literature to define and shape their ethical and professional values. They have not similarly developed or utilised models of practice which attempt to link ethical theory with the particulars of physiotherapy clinical practice. The overwhelming development of knowledge concerning informed consent and the principle of autonomy has been to prescribe duties and methods of compliance. Underlying this focus is a general acceptance of the need for informed consent and unquestioned reliance on autonomy, at least as a \textit{prima facie} principle guiding practice.\textsuperscript{131}

The second perspective involved an examination of informed consent in practice, including studies of clinical communication and studies of ethical reasoning. Whilst giving information and educating patients were identified as significant features in studies examining physiotherapists’ strategies of clinical communication, few studies have examined informed consent as a communicative process. Instead, empirical studies of informed consent have

\begin{itemize}
  \item \textsuperscript{130} Magarey, M., Coughlan, B., & Rebbeck, T. (2000a); Guccione, A. A. (1980); Triezenberg, H. L. (1996); Elkin, S. (2001).
  \item \textsuperscript{131} van Hooft, S., Gillam, L., & Byrnes, M. (1995), p 209 describe \textit{prima facie} principles as principles which can sometimes be broken if the circumstances require it. This is an important point of distinction between a principle which represents an absolute moral value because it means that \textit{prima facie} principles must compete with other \textit{prima facie} principles in a given situation. This competition or weighing up may result in a different ethical conclusion and related decision.
\end{itemize}
focused on compliance with prescribed rules and not linked the requirements of informed consent to the processes of communication.

The review has demonstrated that the primary concern in the literature, particularly until recently, has been with what physiotherapists ought to do rather than an analysis of the ethical basis of the obligation. Whilst there is broad recognition of the need for ethics knowledge to be able to adapt to changing healthcare environments, what is missing in the physiotherapy literature is a discussion of the underlying ethical theory of autonomy, and how that meaning can be incorporated into the clinical physiotherapy communicative discourse, including the processes of clinical reasoning.

**Conclusion**

Based on the review of the physiotherapy literature in this chapter, I have established that there is a body of knowledge about how physiotherapists make clinical decisions and how they communicate. Whilst that is so, the underlying values and ethical meaning of informed consent and associated communicative and practice behaviours that would acknowledge such meaning have been largely unexplored. There has not been a consistent and logical development of the idea and meaning of autonomy as an ethical principle underlying informed consent. There is a corresponding lack of empirical examination of the particulars of physiotherapy practice from the perspective of how to best fit underlying ethical values stipulated as necessary. The capacities of patients attending physiotherapy to exercise autonomous choices have not been fully articulated and the influence of factors, such as how the content of the clinical communicative discourse may enhance or restrict a patient’s capacity to exercise their autonomous rights, has not been investigated.

The next chapter will outline the methodology and method employed in this research to examine therapists’ clinical communication with their patients. The focus of the empirical examination concerns the gaps in the literature identified within this review chapter. That is, the communicative practices of physiotherapists, their interpretation of the ethical obligation of informed consent and an analysis of how therapists’ communication does or does not accommodate the underlying ethical theory of autonomy.
CHAPTER 5: Research design: constructing meanings

Introduction

This chapter is the point of departure for the empirical component of the research. My main aim in this chapter is to explain and justify the design and method which underpins this component of the research. A secondary aim is to link the literature review and discussion in chapters two to four, to the empirical component of the research in chapters six to eight. I begin with this secondary aim by highlighting key features of the process and meaning of informed consent derived from different layers of the iceberg framework. That is, those features which I use to guide and inform the examination and analysis of clinical practice.

Looking back and looking forwards: an overview of phase one to guide phase two

In this section, I identify key descriptive and evaluative criteria about informed consent developed from chapters two to four. The descriptive criteria comprise features of the informed consent process derived from theories of autonomy and different models of informed consent. The evaluative criteria consist of features of informed consent which encompass the ideal of an ‘ethically enriched’ process of informed consent. Both the descriptive and evaluative criteria are used in my exploration and analysis of actual physiotherapy practice.

In chapter two I examined and defined informed consent using an ‘iceberg’ framework. This framework encompassed the underlying ethical theory of autonomy, bio-medical ethical principles, legal guidelines and professional response to the obligations of informed consent. On the basis of this review, I developed a conception of ‘ethically enriched’ informed consent. Referring to foundational ethical theories of Kant and Mill, and from theories of autonomy developed by Dworkin and Young, I argued that an understanding of autonomy at the level of ethical theory, results in a shift in attitude about informed consent. Importantly, it facilitates reflection about a range of influences that might impact on another person’s right to autonomy and capacity to exercise that right. I contrasted this attitudinal approach with an understanding and implementation of the elements of informed consent derived from a ‘compliance with duty’ approach. On the basis of its relatively superficial
acknowledgment of underlying theory I suggested that this latter approach would result in a more superficial and limited implementation of informed consent.

As a consequence of my development of the ideal of an ‘ethically enriched’ process of informed consent, I was able to identify a number of evaluative criteria present in the implementation of this type of informed consent process. According to this gold standard of ‘ethically enriched’ informed consent, the criteria which should be present include:

1. Respect for a patient’s equal ability to reason. According to this criterion (derived from Kant’s ideas of reason and self reflection\(^1\)), there should be evidence of a critical awareness of one’s own values and reasons for giving information to a patient in addition to an awareness of the values, desires and capacities for reasoning in the patient.

2. Allowing a patient freedom to choose and ensuring that their choice results in patient satisfaction or happiness. Here I am referring to Mill’s ideas of both freedom and individual happiness.\(^2\)

3. Promotion of a patient’s capacity to distinguish between first order (primary) desires and second order desires (derived from Dworkin’s ideas of capacities for reflection\(^3\)). This includes recognising barriers and opportunities that may restrict or facilitate patients’ abilities to reflect on their desires and to make choices.

4. Concern for how choices and information fit into the patient’s overall life plan or approach to life. The influence of Young’s ideas about occurrent and dispositional autonomy are influential in this criteria.\(^4\)

During my analysis of therapists’ communicative actions in the clinical encounter and their discussion of informed consent in the interview, I refer to these evaluative criteria as a point of analytic comparison between clinical practice and ideals inherent in ethical theory.

In chapter three I established that the way autonomy is incorporated into methods or models of implementing informed consent also results in identifiable features of the informed

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2 Mill, J. S. (1991). Here I use the term happiness in the sense that the patient is able to say ‘I feel happy with the decision I have made.’ This sense of happiness also covers patients’ different desires and actual capacities to be involved in any decision-making. In practical terms, it means that the therapist needs to make some effort to ascertain the patient’s individual level of ‘happiness.’
4 Young, R. (1986).
consent process. The specific descriptive features of informed consent derived from these models are indicators of what informed consent might look like when it is happening. These descriptive criteria consist of:

1. Therapists formulating the goals and type of treatment and the patient giving their agreement to proceed.\(^5\)

2. Therapists providing explanations of their clinical reasoning and justification for their treatment to the patient in a transparent and accessible way.\(^6\)

3. Evidence of contributions from both the patient and the therapist as to treatment options and procedures.\(^7\)

4. Inclusion of patients’ values and explicit acknowledgement of the patient’s role in contributing to treatment decisions.\(^8\)

5. An ongoing conversation between therapists and their patients where therapists actively provide opportunities for patients to contribute to treatment plans and decisions.

As indicators of what informed consent might look like within clinical communication, these features will be used to guide my examination of therapists’ patterns and strategies of clinical communication.

In chapter four I examined physiotherapy-based ethics and clinical practice literature to provide an account of how the physiotherapy profession has explicated ethical and legal obligations to obtain patients’ informed consent to treatment. I found in this literature that there had been little in-depth exploration of the ethical meaning of autonomy as it applies to the clinical practice of obtaining informed consent to treatment. Instead the focus of the physiotherapy profession has been on how to comply with the stated elements of informed consent. In this literature review, I also found that therapists were interested in the process and effects of clinical communication, but had not linked those effects to informed consent. In other words, the process of obtaining informed consent has been regarded as a separate issue and external to the methods of clinical communication. This review provided background information about the ethos and principles of physiotherapy practice,

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\(^7\) Derived from the shared decision-making model by Charles, C., Gafni, A., & Whelan, T. (1997).

particularly in relation to interpretation of ethical ideals in the context of clinical communication. It therefore provides a further point of comparison for my examination and analysis of actual practice.

Chapters two to four comprise phase one of the research. They have involved a critical exploration of the influence of the ethical theory of autonomy, associated ethical principles and legal guidelines. In the second overall phase (the empirical phase) of this research, I examine therapists’ approaches to obtaining patients’ informed consent in the communicative context of actual clinical physiotherapy practice in the private practice setting. I also examine individual physiotherapists’ attitudes towards and interpretation of the ethical obligation to obtain informed consent within their clinical practice. I focus on understanding the clinical communicative interaction as a whole. I then consider how well and in what ways the interaction fits or does not fit with theoretical ideas of informed consent and autonomy.

The remainder of this chapter is concerned with the primary aim stated at the beginning of the chapter, to explain and justify the methodology and method of empirical examination of physiotherapists’ clinical communication and interpretation of informed consent.

**Phase two of the research: Two layers of enquiry**

I conducted the research in two overall layers. Table 5-1 provides an overview of the empirical research design. That is, the influential theoretical paradigms used, the different research questions posed during the examination, the methods of data collection and strategies of analysis. This summary provides the basis of the discussion for the rest of the chapter.

In the first layer of the empirical investigation I developed a questionnaire designed to seek information from a broad group of physiotherapists as to their interest in, awareness of and their view of the need for informed consent. The questionnaire was distributed to physiotherapists attending a physiotherapy conference and to two groups of therapists attending lecture evenings. I developed the questionnaire in the first six months of beginning this thesis and the results provided me with increased sensitivity to and awareness of the ways that informed consent might be interpreted and positioned within the clinical encounter. This information was then used to guide the development of the second and more significant layer of investigation.
In the second layer, the method of investigation consisted of audio-taping and transcribing seventeen individual physiotherapy treatment sessions, followed by semi-structured interviews between myself and the participating physiotherapists. I discuss these methods in detail later in this chapter. Audio taping of treatment sessions was designed to capture what therapists said to their patients and to enable description and interpretation of the communicative interaction. Semi-structured interviews of therapists aimed to explore their understandings and interpretations of principles of physiotherapy practice and clinical communication generally, and more specifically in relation to obtaining informed consent. This approach of combining both audiotaping and interviewing derives from an understanding that knowledge can be constructed by examining and interpreting both actual practice and individual’s understanding of practice.⁹

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CHAPTER 6: Structure of clinical communication: Building clinical fences

Introduction

This chapter is the first of three findings chapters. In presenting the findings of the empirical component of this research, my intention is to build a conceptual picture of physiotherapy communication within the private practice context. I construct the picture by layers of description, interpretation and analysis of transcript data derived from both audio-taped treatment and interview data. In this chapter, there are two main aims. First, to describe the overall structure of therapists’ clinical communication and, second, to look behind that structure at the meanings conveyed through their communication with their patients. In this analysis I rely only on the treatment transcript data. As outlined in chapter five, my analysis of the data proceeds through a series of steps, beginning with thematic coding, followed by segmentation of the data into categories and then building conceptual understanding from the categories. Throughout this coding process I explicitly draw from the elements and processes of Strauss and Corbin’s paradigm model of data analysis. I use this model and associated analytic questions concerning the context and conditions impacting on therapists’ communication and strategies of interaction as a framework to guide my analysis of the data.

In this chapter I begin with a summary of my findings from the questionnaire, and importantly, an explanation of how I used the findings to guide the second layer of enquiry. Following this section, I discuss the structure of therapists’ clinical communication (building clinical fences) breaks (gaps in the fences), and finally an examination of ‘physiotherapy speak’ behind the clinical communicative fence. Based on the findings in this chapter, I am able to construct a picture of the structural features of therapists’ clinical communication with their patients and suggest how that structure and the messages conveyed within it, might impact on the process and ideals of informed consent.
**Questionnaire results**

In the first layer of the research, I collected both quantitative and qualitative data from three groups of physiotherapists.\(^1\) The aim of this questionnaire was to provide me with a more informed starting point from which to commence the main empirical research, that of qualitatively examining the clinical communicative encounter, including therapists’ perspectives of that encounter. The quantitative data was analysed using descriptive statistics\(^2\) and the questions seeking explanation from respondents were analysed for key themes and concepts. A total of one hundred and thirty-two respondents completed the questionnaire. The overall finding of the questionnaire highlighted a diversity of views, understandings and practices in relation to both information disclosure and practice of obtaining patients’ consent to physiotherapy treatment. In the section below, I present the general themes raised by the questionnaire. I do not intend here to provide a full and formal report of the questionnaire. As outlined in chapter five, the questionnaire was distributed amongst a group of physiotherapists attending an educational conference and evening and weekend lectures. Whilst this impacts on the external validity of the results, my use of the results and consequent aim in summarising them below, is to identify key areas relevant to further enquiry.

**Theme 1.** The majority of respondent therapists had an awareness of the issue of informed consent related to physiotherapy practice.

This was evidenced by the fact that 65.9% of the respondent physiotherapists (including those who currently use manipulative therapy of the cervical spine and those that do not practice in that area) had read the Australian Physiotherapy Association (APA) guidelines about informed consent and cervical manipulation. This suggested that there was a fairly wide interest in clinical guidelines relating to informed consent. I interpreted this theme to indicate a demonstrated interest in or at least a preparedness to read practice guidelines or educational material to assess its professional relevance.

**Theme 2.** Physiotherapists regarded the level of risk associated with a treatment as a relevant issue in deciding what information to give to patients.

Physiotherapists sampled from this population were influenced in their decision-making about the amount and type of information to provide patients by their perception of risk inherent in

\(^1\) Details of the three groups are discussed in chapter five.
\(^2\) The descriptive statistics comprised graphing the points along the visual analogue scale and other measurable responses. These graphs are presented in appendix 4.
treatment, and by their current use of cervical manual therapy techniques. Questions nine and ten, a comparison of respondents’ ratings of the importance of different types of information for cervical spine treatment (regarded as having a high associated risk) and treatment for a moderate ankle sprain (regarded as low associated risk), resulted in significant differences. Provision of information about treatment risks and benefits was viewed by all respondents as more important to disclose for the higher risk treatment of manual therapy for the cervical spine. As further evidence of the theme of risk recognition guiding informed consent, therapists chose cervical spine manipulation as the most influential treatment type influencing their decision to obtain informed consent. This was chosen by respondents over four other broad categories of treatment, neurology, cardiothoracic, sports medicine and cervical manual therapy without manipulation. These categories are too broad and ill defined to make any firm conclusions other than as a trigger to investigate, in a more in-depth and qualitative way, what types of treatments and patient problems physiotherapists regard (in their everyday practice) as significant for obtaining patients’ informed consent.

The responses relating to information disclosure and treatment risk are consistent with legal obligations to address risks (and benefits) enabling a patient to make a treatment decision. However, insofar as respondents distinguished between the amount and type of information to be given to a patient according to the level of perceived risk, a possible interpretation is that their responses are not cognisant of the broader ethical obligation to enhance a patient’s autonomous decision-making, based on broader criteria of risks, benefits and alternatives for all treatments. On the basis of this broader ethical approach, information would be provided because patients have an autonomous right to that information, irrespective of associated risks from the treatment. I also interpreted this theme as a piece of a puzzle requiring much more contextual and background information to further understand the factors that influence therapists’ decisions as to what information should be discussed with patients about risks and benefits of, and alternatives to treatment.

Theme 3. Patient’s wishes were regarded as the most significant factor determining how much and what type of information a physiotherapist would disclose to a patient.

In this question (question thirteen), therapists could also choose time available; their assessment of patients’ ability to understand information and the type of treatment to be given, as factors

---

3 In Rogers v Whitaker, p 489, discussed in chapter two, the High Court outlined the duty of health professionals to inform patients of risks, benefits and alternatives of any treatment procedure
4 See for example, Coy’s discussion of autonomy enhanced informed consent in Coy, J. (1989).
which might impact on the amount and type of information they gave to patients. The results for this question indicated that therapists do consider a number of factors before giving information to patients, and they distinguish between what the patient desires, the time available and potentially many other factors. Again, highlighting a need for further qualitative examination.

Theme 5  Therapists recognised informed consent as relevant to a wider range of clinical situations than just the treatment area of manipulation of the cervical spine.

Therapists raised the need to develop guidelines about informed consent and methods of clinical implementation to apply to a variety of patient and problem types. This theme emerged when respondents were asked (in the final question) for their opinion about the significance of informed consent in the physiotherapy patient relationship and how the (Australian) Physiotherapy profession has handled it so far. Eighty-five percent of all respondents answered this question with a written response.

Three distinct themes emerged from the analysis of their written responses. The first was that different types of physiotherapy treatment have been left out of the current debate on informed consent. Related to these comments, therapists raised the need to develop guidelines and methods of clinical implementation concerning informed consent to apply to a variety of patient types. The second was that informed consent was significant because of the threat of litigation, and the third, that it was important because it empowered the patient.

The most commonly occurring theme was the first one. Respondents commented on a need to develop guidelines about informed consent to apply to all patient types, not just patients who receive treatment with a high level of risk, such as manipulation. The following quotes provide examples of the first theme:

Increased awareness of how it relates to the area of spinal manipulation, but little emphasis on the issue in other areas of physio unless covered by formal research projects.

Cervical manipulation has been investigated and dealt with. Other areas of physiotherapy have risks also, which have not been dealt with in such detail. Exercises are frequently dismissed as low risk but are they really? Exercises do need consent and description of risk – heat/electro etc. are taught as requiring a warning but not as needing consent.

It has been handled moderately well but only when it relates to manipulation. The profession is more aware of the issues as a result of the new manipulation protocol. However the new manipulative protocol was developed because the older protocol was not being adhered to by members. This is not a good reason to introduce a new less rigorous test. Otherwise informed consent is not considered a major issue by non manipulative therapists and this probably needs addressing.
I feel at times physios can get sloppy about informed consent, eg. when using hot packs – it seems that there are assumptions that clients who have had it before remember the warnings and these are not always covered again. In the more 'risky' treatments this is probably better managed.

More emphasis in in-patient settings – and more under-graduate education required. Students tend to tell patients rather than ask.

The profession has only considered this for manipulation and not for other treatments involving some risk, for example, electro therapy.

Related to this group of findings were a few responses that indicated agreement with the need for informed consent, however the responses reflected difficulty with the practical method of application:

Profession is struggling with this. It is unclear what procedures require informed consent and how to go about it.

In legal environment, essential but not well taught at my training – daunting to apply in practice.

It is very difficult to implement and requires a change of thinking in view of recent liability events.

Important but difficult!!

The second most prevalent theme to emerge was that informed consent was significant because of the threat of litigation:

Very significant – good that there is now a protocol for pre-manipulative testing, but there is possibly a need for more protocols for consent with other treatments due to the way society is heading regarding litigation and in order to further protect both the therapist and the patient.

Obviously becoming more important due to more litigious population, but due to time, money constraints forms needs to be user friendly and time efficient only necessary for high risk treatment (at the moment).

Increased vigilance in the legal obligations because of increased litigation but ethically okay.

In legal environment, essential but not well taught at my training — daunting to apply in practice.
The third and least commonly occurring theme was that informed consent was important because it had the possibility of empowering the patient:

I think it's vital – so far not done/emphasised enough. I have heard colleagues discuss what doctors do and don't get consent for - relative risks of medical versus physio procedures. I think it is irrelevant that doctors have literally been getting away with murder. The public are becoming more educated and should rightly expect the opportunity to intelligently participate in treatment decisions – especially those that involve risk.

It improves the relationship by empowering the client which in theory may influence the efficacy of treatment and the outcomes for that patient.

'I informed consent is highly significant, and requires a high profile in the clinician/patient interaction. Too many clinicians consider it their prerogative to administer treatment rather than work in partnership with the client.'

Informed consent is pivotal to the professional relationship.

The results of this questionnaire raised more questions than answers. They highlighted the need for the inclusion of different contexts, including different therapists, different patient problems and different clinical environments as important components in understanding the nature and form of professional knowledge about this particular ethical obligation. The responses also confirmed the suitability of a qualitative method, such as grounded theory, as an appropriate method to use in the second layer of investigation because it highlighted that the phenomenon of communicating with patients in clinical practice is a complex and contextually-based one, dependent on physiotherapists’ theoretical knowledge, area of practice and personal attitudes, amongst other possible factors. In the next section, I present findings from my analysis of the audio-taped treatment transcripts. I begin with a description of the structure of the clinical communication.

**Building clinical fences: structure of clinical communication**

Therapists’ communication with their patients conformed to a recognisable structure and style with three distinct phases consisting of assessment, diagnosis and treatment. During the assessment phase, therapists sought information from their patients about the nature and history of their problem, including its impact on their lifestyle and functional abilities. This was followed by a phase of physical assessment. In the diagnostic phase which followed, the therapist’s clinical reasoning and diagnostic thought processes were communicated to the patient.
Giving the patient information about the treatment and advice about self-management strategies was the final phase of the treatment encounter.

In the following section, I feature one therapist, Joseph (T14) to illustrate the structured nature of the clinical interaction because his treatment provided the clearest example of this approach. The structure of Joseph’s interaction stood out for its clarity and order. The same structure was visible, although more flexibly packaged, in all other treatments. Although Joseph is fluent in English, it is not his first language, and at times his expression appears a little stilted, possibly because of this. In the memo I wrote after listening to Joseph’s treatment transcript, I noted:

This treatment used a classic structured clinical reasoning approach to examination and diagnosis. It followed a clear structure. The problem was localised, treated and the patient was given self management strategies.

Memo written after listening to tape

A key feature of a structured clinical reasoning approach is to methodically gather information to form hypotheses, and to logically and individually test those hypotheses. The language used in this approach reflects objectivity and precision. The approach was first developed as an hypothesis oriented model by Rothstein and Echternach. Jones et al. describe the approach in the following way:

Re-assessment either provides support for the hypotheses and chosen course of action or signals the need for hypothesis modification/generation or further data collection and problem clarification (eg, additional physiotherapy examination or referral for other specialist consultation)

In chapter five, I explained my abbreviation for reporting from both treatment and interview. (T) represents treatment transcript. (14) represents the treatment number. Each therapist’s name is a pseudonym.


Jones, et al.\(^8\) summarise this model and Table 6-1 below is my representation of that summary. Although there have been several studies and related discussions in the physiotherapy clinical reasoning literature that have expanded and elaborated on this early model\(^9\), it nevertheless represents the basic structure and approach underlying physiotherapy clinical reasoning.

**Table 6-1: Hypothesis oriented model of clinical reasoning\(^{10}\)**

<table>
<thead>
<tr>
<th>Number</th>
<th>Step</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Collect initial data by interview or subjective examination.</td>
</tr>
<tr>
<td>2</td>
<td>Generate a problem statement and establish functional or disability related goals.</td>
</tr>
<tr>
<td>3</td>
<td>Collect further data by physical examination.</td>
</tr>
<tr>
<td>4</td>
<td>Generate hypotheses related to achievement of goals, including criteria for testing hypotheses.</td>
</tr>
<tr>
<td>5</td>
<td>Plan re-evaluation methodology for examination of impairment and disability.</td>
</tr>
<tr>
<td>6</td>
<td>Plan treatment strategy based on hypotheses.</td>
</tr>
<tr>
<td>7</td>
<td>Plan tactics (specifics of treatment) to implement strategy.</td>
</tr>
<tr>
<td>8</td>
<td>Implement tactics.</td>
</tr>
<tr>
<td>9</td>
<td>Reassess to check whether goals have been met.</td>
</tr>
<tr>
<td>10</td>
<td>Continue to modify treatment, or generate new hypotheses accordingly.</td>
</tr>
</tbody>
</table>

The approach is currently used in postgraduate education at The University of Melbourne, where I completed my Masters in manipulative physiotherapy in 2000.\(^{11}\) The aim of such an approach is to obtain an accurate and focused (symptomatic) diagnosis and to enable a logical and evidence-based progression of treatment.

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11. After examining each patient, a form would be completed requiring answers along the lines of points 1 to 10 in table 6-1. An example of this form is in Appendix 5.
Joseph’s use of scientific and reductionist language is an exemplar of a typical hypothesis oriented or hypothetico-deductive approach, which, as table 6-1 demonstrates, relies on the generation of hypotheses, generalisations and predictions.

As a physiotherapist who has similarly been educated in this approach, I recognised its phases, structure and goals. As a researcher standing back and analysing the possible ‘other’ effects of this communication structure, I suggest that the approach leaves little room for the patient’s voice and contribution other than to respond to opportunities to provide feedback about the effects of the treatment.

Tables 6-2(a) to (e) are excerpts from Joseph’s treatment. The patient in this treatment was a woman who presented with thoracic back pain. She had recently had her first child (five weeks ago). The first table (6-2(a)) provides a chronological list of the questions Joseph asked of his patient at the beginning of the treatment. There were in fact seventy questions in this phase of Joseph’s assessment. I have included the first seventeen only as they provide a representative sample of their style and content. Table 6-2(b) starts at the point, where the questioning became more physically oriented, that is, part of the physical examination phase.

In Table 6-2(a) the questions are directed at defining and clarifying the site of pain (see for example, questions 4, 9, 11), establishing the cause and assessing the nature of the pain (5) and seeking the extent of the pain (6). The questions are a mix of both open (1, 5, 9) and closed questions, but the focus is clearly to define and classify the patient’s symptomatology. It is particularly noticeable here that the patient’s responses are mostly reduced to simple and non-expansive answers. Although the patient on several occasions began to tell her story or her interpretation of her problem (3), (4), (13), the questions from Joseph mostly focused on his more specific agenda. They do not follow the content introduced by the patient at the time it was introduced.

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13 The patient’s responses are in italics below each of Joseph’s numbered questions.
Table 6-2-a: Initial Assessment

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Ok. Right. How can I help you then?</td>
</tr>
<tr>
<td></td>
<td><em>Um, it’s a similar problem to what I came with last time. I don’t know if you have it there - I’ve just had a baby, five weeks ago.</em></td>
</tr>
<tr>
<td>2.</td>
<td>Five weeks ago, yes.</td>
</tr>
<tr>
<td></td>
<td><em>Yeah. And it was a caesarian.</em></td>
</tr>
<tr>
<td>3.</td>
<td>Ok, yep.</td>
</tr>
<tr>
<td></td>
<td><em>I’ve recovered really well, that’s fine, but I can feel my back is quite sore and I had some work in the hospital as well. Umm, in two places this time. One, I think, around about here…</em></td>
</tr>
<tr>
<td></td>
<td><em>And it’s similar to what I had last time and it feels as if it locks. The times I’ve come before it’s actually locked and you’ve been unable to unlock it. This time it hasn’t locked yet, but I can feel it starting to.</em></td>
</tr>
<tr>
<td>5.</td>
<td>What sort of pain?</td>
</tr>
<tr>
<td></td>
<td><em>Um, it’s like a sharp pain.</em></td>
</tr>
<tr>
<td>6.</td>
<td>Is it there all the time?</td>
</tr>
<tr>
<td></td>
<td><em>No. Umm</em></td>
</tr>
<tr>
<td>7.</td>
<td>So it just comes back.</td>
</tr>
<tr>
<td></td>
<td><em>Sort of when I twist, when I’m twisting or moving.</em></td>
</tr>
<tr>
<td>8.</td>
<td>Twisting and moving.</td>
</tr>
<tr>
<td></td>
<td><em>Yeah.</em></td>
</tr>
<tr>
<td>9.</td>
<td>What do you mean by moving?</td>
</tr>
<tr>
<td></td>
<td><em>Umm, more probably when I’m lifting. Probably the baby.</em></td>
</tr>
<tr>
<td>10.</td>
<td>The baby.</td>
</tr>
<tr>
<td></td>
<td><em>Yeah, lifting the baby.</em></td>
</tr>
<tr>
<td>11.</td>
<td>Ok. So does it happen every time you lift the baby?</td>
</tr>
<tr>
<td></td>
<td><em>(pause) No, but it’s getting more.</em></td>
</tr>
<tr>
<td>12.</td>
<td>More?</td>
</tr>
<tr>
<td></td>
<td><em>It is increasing, yeah.</em></td>
</tr>
<tr>
<td>13.</td>
<td>So how long did it take before that pain settled?</td>
</tr>
<tr>
<td></td>
<td><em>Umm, it was virtually a couple of days after I had the baby it started. So…just in that one spot. And the other thing is…just in here around my shoulders, my whole pregnancy I had a pain. I’ll show you on here (laugh) Um, sort of right in here.</em></td>
</tr>
<tr>
<td>14.</td>
<td>Around the</td>
</tr>
<tr>
<td></td>
<td><em>Yeah, especially my left hand side.</em></td>
</tr>
<tr>
<td>15.</td>
<td>Yep. Around about there.</td>
</tr>
<tr>
<td></td>
<td><em>The whole pregnancy, my husband would constantly rub it at night.</em></td>
</tr>
<tr>
<td>16.</td>
<td>Mmm.</td>
</tr>
<tr>
<td></td>
<td><em>And I can still feel it, like I can still feel really tight.</em></td>
</tr>
<tr>
<td>17.</td>
<td>On both sides?</td>
</tr>
<tr>
<td></td>
<td><em>On both sides.</em></td>
</tr>
</tbody>
</table>

In the physical assessment phase of the treatment, table 6-2(b), the questions and focus are also related to reproducing and locating the patient’s pain through the assessment technique of active movement testing. During this phase of the treatment, the patient’s ability to add her opinion or interpretation was much further reduced, and as illustrated in the patient’s responses in table 6-
2(b), the answers were minimal and I suggest illustrate a type of conformity to a passive and compliant patient role.

Table 6-2-b: Physical Assessment

| All right. then. You have to come to the movement...test. So I would like to look at your middle back first. |
| Mmm. |
| If you would like to put your hand like this. Right. Is there any pain? |
| No. |
| Ok. Try and keep your elbows together, and try to point it up towards the ceiling. That's good. |
| I'm feeling it sort of now. |
| Try and go a bit further. There, ok? |
| Yep. |
| How about trying to touch your opposite shoulder with your elbow. Does that still hurt? |
| No, that feels fine. |
| Elbows out like this. Try to turn. Anything? |
| No. |
| Can you go a bit further? |
| Yep. It feels good. (laugh) |
| Feels good? Oh, that's good. How about the other side? (pause) Feels good? |
| Yes, feels ok. |
| Ok. Then sideways. |
| Feeling it now. |
| On that side? |
| Yes. |
| Over the other side. |
| Still on the same side but I can feel it just there. |
| Put your arms up like this. No problem? |
| No. |
| Like that. No problem? |
| No. |
| Like that? |
| (pause) No. |
| No problem, ok. Can you turn your head. No pain? No? |
| No. |
| The other side. |
| No. |
| Put your head down. No? |
| No. |
| And up again. |
| (pause) No. |
| (pause) I'd like you to lie on your stomach here. |
| Uh huh. |
| Just going to do the palpation. You may need to take off...your t-shirt off. |
| T-shirt off? Yes. |
Following examination of the patient’s movements, Joseph used palpation of the joints of the spine to further locate the source of the pain. This palpation of his patient’s joints and spinal muscles merged into the actual treatment, involving mobilisation by physical pressure on particular spinal joints. In this treatment, as in many of the other recorded treatments, the physical examination merged into the actual treatment. The role of the patient during the treatment phase of the encounter shifted from answering questions to providing feedback about the physical effects of the treatment.

Table 6-2(c) provides an excerpt of Joseph’s treatment phase. The therapist’s role, as Joseph’s excerpt demonstrates, was to locate and alter the source of the pain. Throughout this treatment phase Joseph’s main aim was to link the physical palpation and movement of specific joints and structures to the site and source of the patient’s pain.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>119</td>
<td>Not on...not on the side?</td>
</tr>
<tr>
<td></td>
<td>No.</td>
</tr>
<tr>
<td>120</td>
<td>So it’s mainly here.</td>
</tr>
<tr>
<td></td>
<td>Mmm</td>
</tr>
<tr>
<td>121</td>
<td>Seems gone now.</td>
</tr>
<tr>
<td></td>
<td>Oh no, there it is. It’s there.</td>
</tr>
<tr>
<td>122</td>
<td>There?</td>
</tr>
<tr>
<td></td>
<td>Yep.</td>
</tr>
<tr>
<td>123</td>
<td>Ok. (pause) Keep telling me the pain when I keep pushing like this.</td>
</tr>
<tr>
<td></td>
<td>Yes. It seems to be making it easier.</td>
</tr>
<tr>
<td>124</td>
<td>Making it easier?</td>
</tr>
<tr>
<td></td>
<td>Yeah.</td>
</tr>
<tr>
<td>125</td>
<td>Ok, good (pause).</td>
</tr>
<tr>
<td></td>
<td>Now it’s disappeared.</td>
</tr>
<tr>
<td>126</td>
<td>(pause) It’s gone now?</td>
</tr>
<tr>
<td></td>
<td>Yeah.</td>
</tr>
<tr>
<td>127</td>
<td>(pause) Now, a bit higher.</td>
</tr>
<tr>
<td></td>
<td>Mmm, a little bit sore there.</td>
</tr>
<tr>
<td>128</td>
<td>Uh huh.</td>
</tr>
<tr>
<td></td>
<td>A bit sore.</td>
</tr>
<tr>
<td>129</td>
<td>(pause) Still sore?</td>
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<tr>
<td></td>
<td>Yeah.</td>
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<tr>
<td>130</td>
<td>Any change of the pain?</td>
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<td></td>
<td>(long pause) Yeah, it’s feeling a bit easier.</td>
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<tr>
<td></td>
<td>Mmm. (long pause) Have you tried hot pack yourself at home?</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>131</td>
<td>Ok. (pause) I guess you just didn’t have time?</td>
</tr>
</tbody>
</table>
Table 6-2-c: Treatment

<table>
<thead>
<tr>
<th>No.</th>
<th>(laugh)</th>
<th>(pause) I think the best treatment for you is to give you a bed and a good sleep</th>
<th>(pause) How’s the pain now?</th>
<th>Uh huh. (pause) How a bit higher?</th>
<th>(long pause) How’s the pain now?</th>
<th>Still there?</th>
<th>Any difference?</th>
<th>Bit easier?</th>
<th>It’s good now?</th>
</tr>
</thead>
<tbody>
<tr>
<td>132.</td>
<td>(laugh)</td>
<td><em>Fall into bed at night (laugh).</em></td>
<td><em>Yeah, (laugh)</em></td>
<td><em>Yeah, it feels good now.</em></td>
<td><em>Still there.</em></td>
<td><em>Um, a bit easier.</em></td>
<td><em>Sore there as well (long pause) It’s getting easier.</em></td>
<td><em>Yeah. (long pause) That’s good, feels good now.</em></td>
<td><em>It’s better, yeah. Just a little.</em></td>
</tr>
<tr>
<td>133.</td>
<td></td>
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<td></td>
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<td>134.</td>
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<td>135.</td>
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<td>136.</td>
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<td>137.</td>
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<td>138.</td>
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<td>139.</td>
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<tr>
<td>140.</td>
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</tbody>
</table>

Tables 6-2(a) to (c) demonstrate how the direction and flow of the assessment and treatment is clearly being controlled by Joseph. Although the patient is asked to contribute information and give specific feedback about the effect of the assessment and treatment throughout these assessment and treatment phases, Joseph is clearly in charge of the direction and focus of the communicative agenda.

Joseph’s treatment highlighted two further phases of the clinical communication structure, common to all other participants in the research. They involved giving advice, table 6-2(d), and instructing the patient on strategies for self management, table 6-2(e).

These two phases are also recognised by Elwyn et al.\(^\text{14}\) who examined discourse and decision-making in medical encounters. They describe these last two phases of a medical treatment as a single phase where ‘decisions are made and future management agreed’\(^\text{15}\). In the typical physiotherapy encounter, represented by Joseph’s treatment, these phases followed on from treatment decisions already made. They were characterised by a tone of certainty and


rationality on the part of the therapist. There was a sense that the clinical puzzle, presented at the beginning of the treatment, had been satisfactorily dealt with. During these phases, the patient was not expected to contribute, but rather, as demonstrated by the responses in tables 6-2 (d) and (e), their role appeared to be one of compliance with the advice and strategies of self management.

Table 6-2-d: Advice

<p>| | |</p>
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</table>
| 165. | All right and then we will talk about some stretching exercise, both to your upper back.  
|     | Yep. |
| 166. | And also your chest.  
|     | Yep. |
| 167. | Because I find that maybe the way that you, you know, holding your baby and feeding your baby, that’s one thing. Another one is that taking the pram in and out of the car, pushing and pulling the pram.  
|     | Yep. |
| 168. | All right. So that's another something that we have to discuss. Just stay where you are. I'll get you the hotpack.  
|     | (pause) So did you feel the pain worse after the operation, I mean, propped up in the bed for a few days?  
|     | Yes, very much. |
| 169. | Did you feel worse that time?  
|     | Yeah, a lot. |

Table 6-2-e: Self Management

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| 180. | Instead of just using your, you know the upper body strength. (pause) here now?  
|     | That feels good now. |
| 181. | Ok. Now, you may get up and get dressed then we’ll go for the exercises.  
|     | Ok. |
| 182. | (long pause) Just work those six for you. Six exercises. The first one is to stretch your chest mainly, and through your upper back. So you find a corner and then you just move a foot or two from the corner and just let yourself sink into the corner.  
|     | Uh huh. |
| 183. | And by doing this, you feel that you are stretching over your chest and also your upper back.  
|     | Ok. |
| 184. | Ok? And then the second one is simple. You just put your hand behind and then you further stretch over your shoulder and also your chest. Now this one is quite important actually.  
|     | Mmm. |
| 185. | Especially for you. For breast feeding because you are holding your baby like this all the time.  
|     | Yeah. |
| 186. | And you become tight over your chest muscle. And you are hunching your back like this, right. So what I'd like you to do, if you find a door frame or something and hold your hand there, and try to stretch your chest muscle.  
|     | Yep. |
| 187. | All right? You can try it now. You may be amazed that, how tight it is now.  
|     | Yeah. Just sort of hold it here? |

The structure of the exchange was clearly visible in all other treatment transcripts and consistent across a range of patient/therapist variables, including gender, therapist experience,
therapist/patient familiarity and acute and chronic conditions. The potential for variability and indeed the actual variation amongst patients within this study did not result in corresponding variation in the overall routine communication structure and pattern. For example, in treatment six, the patient was a long term patient, who had been seen by Leon up to twenty times previously. The patient has injured his back at work and was receiving payment for his time away from work while injured. This treatment involved very little physical assessment of treatment. However, there were nevertheless clear phases and a recognisable structure within the treatment. The treatment began by Leon (T6) asking the patient: 16

Ok, what have you got to tell me?

Leon-T6-1

What followed was a series of questions and answers related to the patient’s compensation payments as this was his main concern. The clear changeover from the assessment phase concerning the patient’s problem (being the receipt of payments), to the physically oriented assessment occurred when Leon changed the nature of the questioning to the results of the patient’s scans or x-rays. This phase immediately merged into treatment in the form of advice:

Now did the doctor go through the scans with you?

Nup

Have you had a read of the report?

Oh they said they could see the signs of where I had the operation I guess.

Yes, I’ll show you (long pause). Ok. See here, this space here. That’s where they’ve done the operation so the bones, they’ve had to take away some of the bone to get in, to get into the disc

Leon-T6-(50-54)

In this treatment, there was very little physical treatment. However, there were, nevertheless, clear points where the treatment in the form of advice moved into the final phase of giving guidelines for ongoing management. The following example provides an example of this changeover point. Immediately prior to the comments below, Leon was demonstrating how to perform abdominal exercises to the patient as part of the treatment phase. He then changes the direction of the interaction by stating:

16 In all quotes taken directly from the transcript, the patients’ responses are in italics and the therapist’s pseudonym, the treatment number and the transcript line number are below each quote.
Well you’re definitely ready for hydrotherapy. You need to get going this week with it. Three times a week. Get back into it, ease back into it over the next month. It’s definitely three times a week and you know that.

Mmm

Are you going to be doing it with the supervision of anybody or are you going to be doing it on your old program?

Well I just usually do the old program

Leon-T6-104-106

The structured approach to treatment which I found to be a consistent feature in the audio-taped treatment encounters is not a surprising feature of physiotherapy practice. It forms a core component of undergraduate and postgraduate physiotherapy programs and it has been previously described in studies of physiotherapy interactions. However, in the context of this enquiry, I contend that the structured approach potentially impacts on patients’ actual abilities or opportunities to contribute or add their voice to the clinical encounter. It provides an inbuilt barrier or fence that defines the physiotherapy clinical interaction. In addition, the communication structure provides a particular role for the patient, to listen, answer questions and perform specified movements. In contrast, the patient’s role in models of informed guided by ethical theories of autonomy (discussed in chapters two and three), is not limited to agreeing with the therapist’s proposals, or answering questions. Their ‘voice’ is recognisable because their contribution is a valued and intrinsic component of the goals and content of the interaction.

In the next section, I focus on breaks in the clinical fence. It is these breaks that provide opportunities for the patient and the therapist to change their structurally established roles. They are therefore central to my examination of the clinical interaction from the perspective of how the features and criteria of informed consent are present or not present.

Although the breaks provided opportunities for the patient to contribute their opinion and understanding of their problem, as will be discussed below, the ‘breaks in structure’ did not change the overall direction, flow, and therapists’ control of the clinical communication. What was more significant about the breaks in the communicative structure was not so much that they were present, but the way in which both the therapist and patient responded to them. I begin again with Joseph’s treatment and then discuss other examples that highlight different approaches and reactions within the overall phases of communication.

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Gaps in the fence: structural breaks and opportunities

There were some occasions within the interaction where Joseph relaxed the focus and directive manner of communicating. He allowed the patient to add her version and understanding of the cause of pain. Returning to the memo I made when analysing Joseph’s treatment transcript, I noted:

Joseph did follow the patient’s lead and the nature of the questioning was ‘gentle’ enough to allow some opportunities to add her understanding

Memo written after listening to treatment transcript

An interesting feature of these breaks (exemplified by Joseph’s communication) was that, although they allowed some space for the patient’s contribution, the space was not generous enough to also accommodate a change in control of the interaction, such that the patient might be able to take the lead. For example, during the initial assessment, the first opportunity for the patient to weigh up alternatives, or to actively contribute, other than answering a focused and narrow line of questioning, was when Joseph asked:

All right. Comparing these two pains, one is over your neck and shoulder and the other one is a bit lower down. Which one is worse?

Joseph’s response in turn was a minimal ‘yep’. There was little positive acknowledgement and explicit encouragement of the patient in relation to her opinion and her personal ‘clinical reasoning’. On the other hand, Joseph did not close the patient’s communication down. The patient went on (despite the lack of overt encouragement or perhaps because there was no discouragement), to mention some uncertainty about exercises given to her in hospital:

And I’ve been through, like when I was in hospital, they showed me exercises to do and I’ve been trying to do that. Um, but I don’t know if it is, yeah, the feeding

Interestingly the idea of a ‘locked joint’ raised by the patient (line 4 in table 6-2(a)) was clearly stored by Joseph because he later referred to it when formulating the diagnosis and management. In the diagnostic phase of the treatment, Joseph stated:
Now what I feel is that I think you may be right that you have a locked joint (pause) and (pause), it’s not that stiff now. It’s just kind of umm soft tissue tightness all around this area. After the mobilisation, it’s much easier.

Joseph – T14 – 172

Joseph’s use of his patient’s prior contribution was for his own purposes insofar as it contributed to his clinical reasoning. Although the information was given by the patient by taking advantage of a more open question from Joseph within the early part of the treatment, the patient’s response did not meet with an explicit acknowledgement by Joseph of the significance of the contribution at the time it was offered. The structure of the communication phases seemed to provide a barrier to the acknowledgment and use of the patient’s contributions and the related lack of ‘generosity’ of Joseph’s responses were a further constraining barrier. Both Joseph and the patient seemed to have a specific role to play (Joseph to ask questions and the patient to answer them), and both appeared to conform to their roles.

Another example of Joseph relaxing the pace, and allowing room for the patient to respond, was when the patient mentioned in response to Joseph’s questions in the first phase of questioning, that she thought the pain was getting worse. Joseph followed her contribution and seemed genuinely curious about the patient’s opinions and thoughts:

Why is that?

*I don’t know. I don’t know if I’ve (pause)*

Have you done anything different?

*Maybe getting her out of the car. Like I’ve been walking a lot. A lot. And pushing the pram and, I’ve probably got a lot more active because I’m sort of getting back into shape now and being (pause)*

Oh, ok.

*And trying to get fit. So I’ve probably, and I think I’ve probably pushed myself a little bit too much. And getting the pram out of the car.*

Joseph – T14 – (41 – 42)

Even in this example, where the patient was providing more of her story and also seeking some reassurance from Joseph as to her efforts to get back into shape, Joseph was responding minimally or trying to focus the patient’s response, when her initial response was a bit hesitant. When the patient took the opportunity and expanded her explanation, Joseph’s response returns to

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18 Here I am defining generosity as a willingness to act on the patient’s offer of information by either acknowledging its usefulness to the process of diagnosis, or by following up specifically in the next part of the conversation on one of the themes or ideas raised by the patient.
being non-committal even though the information given to him proves to be quite useful. Again, although he did not respond to the patient at this stage (about the fact that pushing the pram may have been a valid cause of her pain), towards the end of the treatment in table 6-2(d), he used the patient’s information to formulate a diagnosis and reasons for the patient’s current pain, stating as a reason for her pain:

And another one is that taking the pram in and out of the car, pushing and pulling the pram.

Joseph – T14 – 167

In other words, Joseph used the patient’s information by taking ownership of it and by inserting it into the structure and purpose of the clinical interaction. Joseph’s invitation to the patient to add more in fact presented a limited opportunity for the patient because it was used to fit into the dominant structure of the interaction which Joseph ultimately controlled.

It is important to highlight variation in the ways that therapists provided structural breaks and the ways that patients responded to these opportunities. For example, at times therapists provided breaks in the communication structure by inviting patients to contribute to the problem solving nature of the enquiry. However the actual opportunity for a patient’s contribution afforded by this invitation (as demonstrated above by Joseph’s transcript) was influenced by the therapist’s ongoing reaction to the patient’s response.

In the following extract, Sean (T17) opens up the questioning by giving the floor (via an open question) to the patient. This has the effect of providing the patient with an opportunity to explain their problem in their own words and to ask for some reassurance about whether the exercises he had tried to relieve the pain, were appropriate. Although the invitation to expand the explanation was made by Sean and taken up by the patient, the reaction by Sean in his response in bold below suggests that he was more interested in pursuing and defining the nature and cause of the symptoms than responding to the expanded information offered by the patient.

Ok, what makes it feel better?

Well (pause)

What do you do when you are in pain? What sort of (pause)

Well, what I have been doing - I don’t know whether it’s right or wrong - I’ve been doing my normal exercises to try and (pause) oh well what do you call it (pause) here against the wall and do my usual ones and then bending. It doesn’t hurt unless I go too far forwards

**Does it ease the pain?**

Well (pause) to a point yes, but (pause) not really because I’m too scared to go too far in case it hurts me.

What about if you lie down?
No. I find it when I’m lying on my back, I can’t get comfortable at all and when I try to roll over, that’s when I feel it worse. But I get into a (pause) the most comfortable, comfortable ah (pause) position is lying on my side.

Ok. So, would you say that eases the pain if you are lying on your side?

Yes, yes.

Ok. Umm (pause) does it wake you up at night, this pain?

Yeah. It did the other night. It didn’t last night because I was that tired (laugh), but the night before, yes I was awake nearly all night because every time I moved (pause) and it was just so painful.

Sean – T17 – 26 – 31

In this example, there appears to be some tension between, on the one hand, providing an opportunity for the patient to expand his story and, on the other, a need to maintain control of the direction and flow of the treatment agenda.

The next three examples illustrate how the ‘structural break’ provided a more generous or at least a real opportunity for the patient to break into the communicative agenda. The first is another excerpt from Sean (T17). In the example below, Sean begins by giving an explicit opportunity to the patient to provide further information. The patient seemed a little taken aback by this sudden expansive invitation\(^{19}\), which in fact seemed almost threatening because it suddenly put the onus on the patient to be the expert. In response to this, Sean narrowed the request down to ‘the back pain’ to reduce the size of the task. The patient did take the opportunity given to him and expressed a concern about the link between his back pain and his foot arches. Sean responded to this request and promised not to ignore the possibility of the link. In this example, Sean allowed the patient time and opportunity to complete his concerns. However, interestingly, the exchange was completed by Sean, which I suggest is an example of maintaining control of the clinical reasoning process by converting the patient’s concerns to a problem he would later solve;

Is there anything that you think I should know about that I haven’t asked you about?

Umm (pause)

About this back pain?

About this pain, not really. The only other thing I was wondering is that, was it ever related to my foot problem that I had. You know when I had the sore under the arches of the foot. You know when I last saw you, or some time ago, and we weren’t sure whether that was (pause) but you didn’t think it was related to the foot.

Yeah. This is the same side.

\(^{19}\) The surprised response was particularly evident in the tone of voice of the patient, in addition to the expressed hesitation.
Chapter 6 – Building clinical fences

The same side, yes.

Umm (pause) I can't say conclusively right now that it's not related. Ok? There is a chance that it is, but so far on what you've told me my clinical hunch is that it's probably not related.

All right, ok.

But I can't (pause) umm (pause) say that categorically now. It will declare itself hopefully over a period of time.

Right, ok. Fair enough.

Ok? So we'll play on and we'll see and we'll keep that in the back of our minds …

yep

Seeing if we can sort of link that up or not.

Sean – T17 – 64 – 70

In the second example of a more generous response by the therapist, Saul (T9) provides opportunities for the patient in the first phase (the subjective examination) to contribute her own opinion and concerns. There is a sense of space between questions and genuine interest from the therapist towards the patient where the patient is able to complete his answers to the questions

Yeah. So where exactly is your pain?

It's sort of above the (pause) above the pelvis and also down in (pause)

Into your buttock?

Yeah.

Because that's where you had it last time when you saw Narelle

Oh right, ok.

Yeah. Does it feel like it's the same sort of problem?

Yeah. Um… I thought for a little while that I was having um (pause) kidney problems but I think it's just my back

Yeah, because it was higher for a while wasn't it?

Yes

Closer to your waist?

Yes

But that's now resolved?

Yes

Saul – T9 – 10 – 15

In the third example, Jean (T4) began the subjective examination with an open question and allowed the patient (who seemed to be quite talkative by nature) freedom to answer. Within the structure and phases of the communication, Jean’s role was encouraging and expansive:
How have you been since last week?

Well after my workout with you, that night it was terrible. I got home and I (pause) before I went to bed I did those… the exercises and might have done it too much, I’m just not sure (pause) um, you know (pause) there was the one where you put your foot on another, and that was a bad night, but then the night before last I found I could lie on my side. That’s the first time I’ve done that since the 20th of February. So that was (pause) last night it wasn’t bad either. So, I have two reasonably good nights and I don’t know if it’s that particular exercise. And whenever I think of it I’m doing my tummy pulling, but I found that very difficult to do but you said do it when you’re bending over (pause) well, you know, you just sort of (pause) I just don’t seem to have the (pause) enough (pause) I do it, you know, if I’m standing up, you know I can do it good and I can do it when I’m sitting down coming in on the train I’m thinking of it.

Good.

You, know. I’m thinking of my posture a lot more too.

Well done. It will probably get easier to do it when you’re doing activities as well and I guess it’s, as much as anything it’s almost on the return from bending over that you need to draw the tummy in to support the spine.

Mmmm.

So that’s (pause)

When I’m doing the dishes (pause) well (pause) you know, I suppose it’s the height or something, but I feel, you know, that it’s all falling forwards, you know, so that I can understand why you are telling me to think of my posture.

Good.

Jean – T4 – 1 – 5

Importantly, there were also variations in patients’ responses to these structural breaks or opportunities. In the next three treatment excerpts, I highlight three different ways that patients reacted to a ‘structural break’ or opportunity presented by the physiotherapist. The first is an example of a patient making very little use of the opportunity offered by the therapist with only a minor change in their level of contribution. The second example demonstrates the patient taking advantage of the opportunity afforded by the break. The third and less common example was the patient proactively seizing the opportunity to contribute without waiting for the invitation from the therapist.

The first variation with Vera (T13) demonstrates a patient who showed little interest in expanding his responses to Vera’s questions, which at times were a specific invitation for him to offer more information, or to give his opinion:

Has there been any leg pain since I saw you last time?

A little bit.

Do you think, is that (pause) how does that compare? Is that better?
Oh, we're improving, yeah.

Yeah, so it's mainly the back or buttock area, and right and left. And how was it after you left here?

(pause) Good, yep yep.

Any problems, any soreness when I've been treating?

No extra soreness, no.

Ok. And have you had any shooting pains?

Um…probably one or two episodes a week. Really progressing, yeah.

And driving too, that was the other time you had had problems

That was much better.

In this excerpt, which was typical of the whole treatment, Vera tried to engage the patient by seeking as much information from him about his problem and explaining all steps of the treatment, however he rarely took the opportunity to give more than brief answers throughout the whole of the treatment. My memo, written after listening several times to this treatment audiotape, also reflects this analysis:

There was a lot of therapist-led explanation in this tape. The therapist seemed to be at pains to explain what the treatment was about and why she was about to do particular techniques. Although this patient had been seen before and the treatment was producing a successful outcome, the therapist was not very relaxed and the patient said very little throughout the treatment.

Memo written after listening to transcript

An example of the second variation in patients’ responses, where they took advantage of the structural break, is found in the following excerpt. Towards the end of the excerpt, Ray (T8) specifically reassured the patient on the basis of the information he had provided about the x-ray results. At this point the patient took the opportunity to add a particular concern about whether or not he needed to come to therapy at all. Ray’s subsequent response was to acknowledge and affirm the patient’s decision to attend physiotherapy, by assuring the patient that they would still gain some knowledge about the nature of the problem and future management by attending for treatment. The point to be made here is that the patient responded when the structure and therapeutic focus of the communication relaxed to allow him to, in this case, seek reassurance:

And the x-ray, the lady had a look at it and she didn't see any fractures.

Yep.
I phoned them today, as well and (pause) just to get the results. I didn't speak to him though. I spoke to the lady on the desk and she said that the report was normal.

Yeah. Which means that um, there's no major fracture.

Yeah.

I mean, usually you pick that up early because you wouldn't be able to (pause)

Yeah.

…to walk on it or you'd have more problems. You may still have a crack fracture. But that won't show up for about ten days.

Oh, ok.

So it's the sort of thing where, where if for some reason you weren't improving (pause) um (pause)

Yeah.

Then you'd have it re-xrayed after ten days. But from everything you've said, you're doing fine.

It seems to me. Yeah (pause) I thought it was a bit embarrassing coming now because it seems to be getting better. Like I'm walking almost normally at home. I mean, I have a shower and it was warmed up a little bit so it felt, it was (pause)

Look it’s still worthwhile because this will give you, even though if you don’t need much more, at least you know what you should be doing.

Ray – T8 – (17 – 53)

The third variation in patient responses is an attempt to proactively take the agenda by the patient rather than respond to the therapist. At the beginning of the treatment the patient in treatment 10 directed the therapist, Ian (T7), to look in the notes for a record of her previous history. The patient gave an explanation for the cause of her symptoms, being triggered by a cold, and suggested that this may be the reason for not being able to stretch and therefore the cause of increased back pain. This information was provided despite the nature of Ian’s questions being fairly closed and directed towards defining the patient’s pain:

When you said back, whereabouts (pause) exactly (pause) lower back?

Lower back. And I think if you look at the notes, you’ll see that I probably have a bit of scoliosis that occurred in my lower back.

Yep.

And the thing that has triggered it this time around is that I had a cold for two weeks…or a little bit more, just two and a half weeks with a cold. And once I had my cold I wasn’t very mobile and I had a lot of muscle ache. And even though I tried to stretch, sometimes I was getting too tired and I couldn’t even stretch. I still wasn’t moving very much and as a result my lower back became stiff.

OK. When was that?

(pause) I've been healthy for one week. So (pause)

So, a week ago it came on

No, I've had the sore back the whole time I've had my cold.

So how long was that?
I've probably had this for about a month now.

Ian – T7 – (13 – 17)

A further example (again from Ian’s initial examination) of both the patient explicitly and proactively seizing an opportunity to present her concerns and, in this case, the therapist ignoring those concerns, is found in the following two excerpts. In the first, Ian is attempting to further define the source and area of the patient’s pain. In the line in bold, the patient is clearly becoming frustrated at the number of questions being asked. (This was question number 53 in the initial examination). Ian’s response is to re-phrase the question:

Is it a pinpoint sort of pain or is it spread into quite a large area

It's (pause) no it's only on the small area but it's not pinpoint. It's probably just like a little couple of centimeters or something.

Yep. All right, do you want to have a seat. Umm (pause)would you say it was a sharp pain or an aching pain? Just (pause) describe (pause)

A sharp sort of pain when I (pause)

Ok. What do you get it with? What sort of activities or doing what sort of things?

Do I have to answer all these! (laugh)

How about (pause) I'll say it different. What about sitting, does sitting make it worse?

No.

Sitting's ok?

Ian – T7 – (52 – 56)

After question 70, the patient again expresses her frustration which is again ignored by Ian (in bold):

So you wake up in the morning and it's quite stiff?

Yeah.

How long does that last for, the stiffness?

(pause)

So, if you, if you have a (pause)

(laugh) This has been going on for a month and I think it's a bit challenging answering the questions.

Yeah, fair enough. Just on, sort of, how are you like at the moment - if you wake up and it's stiff, will the stiffness be there for a long time or does it tend to go away in a few minutes?

No. It would take a fair bit of stretching to try and work it out. So (pause) yeah (pause)
An hour or so?

Yeah, I need to stretch it a little. So I’ve been trying to do stretches in the morning. Unfortunately I couldn’t do any this morning. I ran out of time.

Ian – T7 – 67 – r 71

Ian is concerned with seeking information and defining symptoms. The purpose of his questions are to sort out the variables of where, when and how in relation to his patient’s symptoms. In contrast, the patient’s language is more emotive and more narrative based. There appears to be a lack of congruence in the interaction and because of the barrier put up by Ian, the communication is parallel rather than interactive. Even when the patient protests, Ian does not accommodate her requests. Throughout the clinical encounter between Ian and his patient, the parallel nature of their communication remained relatively stable. Ian patiently and doggedly pursued the same information-seeking focus and his patient continued to challenge the closed focus by actively trying to assert her voice, her meanings, values and interpretations.

Ian’s responses provide a clear example of discordant communication between patient and therapist. That is, a clear example of a mismatch between, in this case, a patient proactively taking an opportunity to assert her concerns, and a therapist not acting on that message. In the earlier examples, therapists provided a break in the therapeutic structure and patients either took advantage of it or did not respond. However, the opportunity, even where therapists did follow the patients’ concerns, did not change the overall focus and direction of the communicative agenda, to achieve a therapeutic outcome, or to solve the patients’ problems.

Summary: recognising clinical fences and gaps in fences

At the start of this chapter I summarised a ‘typical’ or ‘classic’ physiotherapy treatment structure. This structure or clinical fence, I suggested, was built on purposeful and consistent phases of therapists’ communication within the treatment interaction. Closer examination revealed breaks or holes in the clinical fence, which were big enough for a patient or a therapist to step into the other’s ‘place.’ In the context of this research enquiry, both the structure and breaks in the structure of therapists’ clinical communication may be distinguished from the process of informed consent described by models of informed consent. For example, the phases of therapists’ communication which incorporated disclosure of information and explanation of clinical reasoning and treatment justification, are similar to the features of Brody’s transparency
model\textsuperscript{21} and Wear’s event model.\textsuperscript{22} However the communicative structure was less conducive to features of the informed consent process such as promotion of patients’ contributions or inclusion and acknowledgment of patient’s values and beliefs.\textsuperscript{23} In other words, the structured nature of the communication has particular consequences for patients’ abilities and opportunities to contribute to the communicative agenda.

It is also important to note that the structure of the clinical communication does not of itself prevent different ways of implementing informed consent. However, if the structure and the breaks within the structure are not recognised, then it will dominate the overall interaction, and opportunities for more flexible contributions from both patient and therapist are likely to be missed. Other studies of the physiotherapy/patient interaction have similarly demonstrated both an inbuilt structure and purpose and importantly a lack of awareness of possible effects of the dominant structure. For example, in a qualitative study of how physiotherapists relate to and examine patients, Thornquist found a structured and focused interactional approach and suggested, as I have, that therapists were not necessarily aware of the effect of their clinical communicative strategies and approach.\textsuperscript{24} Discussing two different therapists’ approaches to gathering information during the assessment phase of the treatment, Thornquist noted:

In their history-making both therapists controlled the content and form of the dialogues so that the patient’s own version was allowed little place. Their history-taking was evidently a question of making histories without the therapists being conscious of how constructive their role was.\textsuperscript{25}

Research into the clinical discourse of doctors and patients also has resonance with my initial analysis of my data. For example, Mishler characterises the interview patterns of doctors as ‘the voice of medicine’ dominating over the ‘voice of the life world’ of the patient.\textsuperscript{26} Maynard, in his study of doctor/patient interactions, describes a typical example of medical clinical discourse as:

a patient who arrives at a doctor’s office and presents a complaint. The doctor, largely by way of questioning strategies that require delimited responses, works the complaint into bio-medical

\begin{footnotesize}
\begin{enumerate}
\item Brody, H. (1989).
\item Wear, S. (1998).
\item Thornquist, E. (1994).
\end{enumerate}
\end{footnotesize}
categories that lack sensitivity to the patient’s psychosocial concerns, life world and folk understandings.  27

In summary, I contend that an obvious consequence of the structured clinical communicative approach or building of clinical fences evident in this research is that there is little opportunity for a patient to assert an autonomous position. Importantly, the ideals of patient autonomy underlying the process of informed consent are not a natural consequence or by-product of the structure. The structure in effect excludes them.

**Behind the clinical fence: ‘Physiotherapy speak’ – Giving information and asking questions**

In this section I go behind the clinical fence and examine therapists’ communication more closely. That is, I move from the overall clinical structure to unpack therapists’ discourse. The specific questions I asked when analysing the data (listed below), reflect on interest in the underlying meanings and messages conveyed by therapists’ communication:

- What do therapists’ actions and statements take for granted?
- What are the implications of the communicative processes for patient contribution to the clinical interaction?
- What ideals and assumptions underpin the types of information given to patients?

Through this unpacking of therapists’ clinical discourse I demonstrate that what therapists say to their patients sets the agenda for the interaction, by making visible to the patient what matters to the physiotherapist and what matters in the treatment. On the basis of my analysis of the content of information given by therapists to their patients, I argue that the goal of giving such information is not aligned with providing information to the patient for the patient, but rather as a means of justifying the therapists’ aims of treatment and choice of treatment to the patient.

The initial descriptive coding of the content of information disclosed by therapists revealed four main categories.  28 They were therapists seeking information, giving information, instructing the patient or conversing with the patient. In this section, I divide the four descriptive categories into

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28 These categories conformed to the overall structure and phases of the interaction discussed in the preceding section.
two categories of either giving information (‘physiotherapy speak’) or seeking information (‘physiotherapy questions’).

‘Tightness in those muscles’; ‘pain that’s coming from the discs’; ‘draw the tummy in to support the spine’ represents the ‘physiotherapy speak’ of private practice physiotherapy discourse evident in this research. The language reflects a bio-medical framework. It emphasises physical and physiological causes for patients’ problems.

When therapists gave patients information, the content reflected the thought processes and decision-making associated with their examination and management. The categories of the information therapists gave to patients fell into four broad subject areas. They were assessment findings; information about proposed treatments; the nature or cause of the patient’s problem and advice about patient management.

Therapists tended to give information from the first category at the completion of the assessment phases of treatment. In the following example, Saul (T9) is concluding the physical examination of his patient’s hamstring problem. As this quote demonstrates, he immediately starts the explanation or diagnostic phase based on the results of the objective assessment:

   Sorry, I'm trying to...I'm being brutal but I need to localise that (pause) All right. Let me get you (pause) I'm going to just find a picture of the hamstring. I'll show you what I think is going on.
   Saul – T9 – 119

The second distinct category of information related to the proposed or actual treatment, including instructions within the treatment. In the first example below, Linda (T15) gives her patient some information and justification about the proposed treatment. In the second example, Leon (T6) gives information about the type of treatment he is about to give based on the instructions for the type of movement required:

   So essentially we need to stretch out all the tightening in your back and then the other thing is to show you a lot of stomach exercises. That’s a fairly new treatment for these sorts of problems. There’s been a lot of good research in the last four to five years that shows that if you improve your stomach muscle strength, particularly one part of your stomach muscle (pause) then it really does help prevent the occurrences of back pain.
   Linda – 15 – 164

   All right., shirt off as well. So we can see that back and your shoulder. Ok, can I get you to turn to the right as far as you can
   Leon – T6 – 2
Therapists were particularly comfortable when talking about the nature or cause of the patients’ problem. This was the third distinct category. The four examples below all illustrate therapists’ clinical reasoning and thought processes being conveyed to the patient. They emphasise relationships between posture and activities and physiological constructs of healing and the influence of biomechanics:

It’s not until you get that freed up that you realise that tightness in those muscles and how much heaviness you carry through the neck and the top of your shoulders for all those years. But because that becomes the norm you don’t realise it.

Tom – T1 – 200

Keeping in mind the history of your back, I reckon you just landed on it a little bit harder…and that’s what irritated the joint and that’s why when I move it and you stand up it actually feels a little bit better.

Aaron – T3 – 257

Ok. But in your case it seems to be more just a little bit of grinding, the tendons clicking over and the joint is just grinding a little bit. Don’t worry about that.

Leon – T6 – 16

Pain down your leg is often called, a lot of people refer to it is sciatica because some of the nerves which help to form the sciatic nerve, which is the nerve that supplies the muscle in the back of the leg. Some of those nerves may be irritated causing you to feel the pain down the back of the leg

Jean – T4 – 141

The fourth content category consisted of strategies for patient management, including instructions for exercises. Here, as I discussed in relation to Joseph’s treatment, therapists demonstrated certainty and confidence in their attitude and demeanor to patients. As Jean (T4) indicates in the first example below, the advice was sometimes given in conjunction with the treatment and sometimes given, as Rebecca (T5) demonstrates, as a specific exercise, separate to the assessment and treatment:

Well done. It will probably get easier to do when you are doing activities as well and I guess it’s as much as anything it’s almost on the return from bending over that you need to draw the tummy in to support the spine.

Jean – T4 – 5

Bring your right leg behind you. Keep your foot flat, bend down and keep your leg straight and lunge forward like that, sorry…like that. So you can get the lunge and stretch the calf.

Rebecca – T5 – 38
The content of therapists’ communication in this research was highly consistent across all participants. It also conformed to descriptions of the communicative and cognitive work of physiotherapists described by authors who have discussed and examined the process of clinical reasoning of physiotherapists.\(^{29}\) Jones et al., for example, defined clinical reasoning as ‘the thought processes associated with a clinician’s examination and management of a patient or client’.\(^{30}\) The examples above demonstrate that therapists gave clinical reasoning information throughout the treatment.

Therapists also gave their patients information to facilitate their co-operation with the treatment process, including ways they could self-manage the problem and the overarching theme was one of getting a job done. This theme was apparent in treatments involving both first and return visits. Although there were differences in level of familiarity and therefore relative ease of communication between initial and return patients, this was reflected in the amount of initial assessment and the time taken for the therapist to discuss the patient’s main presenting problem, rather than the structure, content and overall direction of the communication.

What is significant from these examples of information given to patients is an overall message of expertise, authority and certainty, an unstated assumption that the patient will comply with the therapist’s information and little expectation that they might contribute differently.

The second main category relating to the content of therapists’ communication is that of therapists seeking information from their patients. Questions, and more particularly who asks them, have been highlighted as significant in previous studies of medical discourse. Ainsworth-Vaughn, in her studies of medical encounters, suggests that to ask a question is to claim power over emerging talk by controlling the topic of the response.\(^{31}\) Focused questions imply an expectation that the ‘floor’ will be returned to the questioner\(^ {32}\) and the ‘floor’ is usually thought to

\(^{29}\) The following studies, previously discussed in chapter four, all give examples of therapists’ clinical reasoning and decision making skills. Jensen, G., Shepard, K., & Hack, L. (1990); Thornquist, E. (1994); Talvitie, U., & Reunanen, M; (2002); Parry, R. (2004).


embody the ‘up’ position in conversational asymmetry.\textsuperscript{33} This is particularly relevant in a medical encounter because the choice of topic ‘determines which of the patient’s problems will be addressed and which will not’.\textsuperscript{34} In my earlier presentation of Joseph’s questions in his subjective and objective examination, the topic of interest was clearly visible, the nature of the answers were expected, and the patient’s problem was controlled and reduced to stiffness of a particular section of the spinal joints. There was a sense of predictability in the questions and answers.

The following section discusses the types of questions therapists asked of their patients, including both the questions associated with the assessment phase at the commencement of the treatment and questions asked to obtain patients’ feedback during the treatment itself. In particular, the effects of different questions on patients’ abilities and opportunities to contribute their ‘voice’ to the treatment encounter are highlighted.

All of the therapists’ opening questions began with an open stem, such as ‘how can…?’; ‘how have…?’ and ‘what have…?’\textsuperscript{33}. Despite this initial open enquiry, a sense of direction quickly developed in the questions. In Figure 6-1, I have listed the opening questions of all participants and categorised them according to three main underlying messages. They were that the physiotherapist ‘was there to help’; ‘to solve a problem’ or to ‘give the patient the ‘floor’. Even in this latter category there was an unstated but overriding proviso that the patient was expected to give the physiotherapist the type of information to which they could attend. That is the floor was not completely open.


\textsuperscript{34} Ainsworth-Vaughn, N. (2001), p 462.
The questions and instructions from Rebecca’s treatment (T5) provide a good example of how the types of questions Rebecca asked ensured that, as the physiotherapist, she had the ‘floor’. The initial message in Rebecca’s first question, ‘What can I do for you this afternoon?’ (in physiotherapist as helper category figure 6-1), quickly changed to a business-like and focused series of questions. In my memo following analysis of this treatment, I referred to Rebecca’s approach as similar to a ‘kind but firm school teacher’. The patient presented with moderately severe calf pain, similar to a tear. The patient’s problem was unusual because there had been no history of any particular injury or overstretch. Rebecca was intent on finding an explanation for
this unusual injury presentation and through her questioning she demonstrated a caring but authoritative approach. The first set of questions asked by Rebecca during the subjective assessment and chronologically listed below, illustrates a very purposive focus:

- whereabouts?
- can you show me?
- and when you actually pulled it, like were you running or..?
- just ordinary walking?
- so when did it first start?
- and initially no other injuries?
- so show me where it isn’t sore

Rebecca – T5 – (1 – 8)

Later in the treatment, when the patient added some extra information, Rebecca’s responses were also business-like and somewhat paternalistic in tone:

> On the circulation point, I had noticed that I have had, like I can't get my feet hot this winter. I've actually have had to put them in warm water a couple of times

And that's a new thing? That's not there normally?

Yes. No. I've always been a bit of a cold body but it's like a problem to me now. I had a bit of a fear of getting cold because my feet are going to not cope.

That doesn't sound like a normal healthy person's circulation does it?

No

Rebecca – T5 – (98 – 100)

Clearly Rebecca’s aim was to help this patient, but equally clearly, as evidenced by the purposive questions and responses, she was the person responsible for the solution.

Another consistent type of questioning present in all therapists’ communication, was that of asking patients for feedback. These types of questions directed the patients to respond in a restricted sense. That is, to provide a response that only related to their level of comfort or their ability to tolerate the effects associated with a particular position, stretch or treatment strategy. The following three examples demonstrate the restricted focus and purpose, being the physical effects of the treatment chosen by the therapist, rather than choices or understanding of the benefits, risks and alternatives to the pre-chosen treatment:

(1) Let me know if you feel any pain at all there from the start… Not much?

Aaron – T3 – 211
I’ll just work very gently. Is that just nudging your pain there? Let me know if it builds up at all.

Tom – T1 – 135

Can I get you to turn over onto your front? (pause) Right, I'm just going to stretch your quads out. Let me know if you're getting any pain or other symptoms. That's ok?

Seth – T16 – 45

In another sense, asking for feedback could be regarded as an opportunity or break in the structure because an indirect effect of obtaining feedback from the patient about what they were feeling during the treatment was that it encouraged the patient to contribute to the treatment, to add their view, and possibly share their concerns and preferences as to the treatment. For example, when Sean (T17) during the physical examination asked for feedback as to the level of pain associated with moving to the right, the patient responded first to the question and then added a little more information:

No it's not too bad (pause). When I was doing that sort of exercise this morning when to the right it was like a shot.

Asking patients for feedback was a consistent and common questioning technique across all the physiotherapy treatments recorded. Part of the explanation for its consistent presence for a range of patient problems is likely to be that it is a cornerstone of the problem solving approach, where therapists work to construct patterns of the patient’s problem based on their past experience, their knowledge about the condition and the patient’s response to their intervention.

The goal of focused questioning according to this approach is to carefully monitor the effects of the treatment intervention so that each treatment can be controlled and measured and the resulting change in symptoms can be traced to a particular intervention or treatment technique. The questions and requests for patient feedback were all asked therefore in the spirit of solving the patient’s problem. One consequence of this aim and process of communication is that it determines and directs the role of patient, that is, to comply with and to co-operate with the therapist’s line of questioning. A broader consequence related to the ideals of an ‘ethically enriched’ process of informed consent is that it allowed patients very little opportunity to reflect on choices, to add their own reasoning or to actively collaborate.
Summary and key findings

In this chapter I have built a picture of the overall structure of therapists’ clinical communication. The clinical interaction had a life of its own, governed by a visible structure, patterns of conversation and defined goals and outcomes. The structure reflected the physiotherapy treatment paradigm of problem solving, reliance on a bio-medical framework and a logical and sequential approach to assessment, diagnosis and treatment.

The main purpose of the structured approach was to achieve the task of solving patients’ clinical problems. Behind this communication structure was an interaction guided by a particular style of seeking and giving information. The content of physiotherapists’ clinical communication demonstrated a recognisable, distinct pattern and consistent focus and purpose. Through their communication, therapists positioned themselves as an authoritative, helping and/or problem solving figure evidenced by the structure, content and style of the language used.

My contention based on these findings is that the opportunities that such language gives or does not give to patients, has consequences for their ability to play an active role in any clinical decision-making during a given treatment session. If the therapist takes a controlling position by use of a therapeutically focused and structured style of communication, the patient’s role was somewhat pre-determined to be passive, compliant and provide information. Although patients occasionally took advantage of breaks in the structure of the communication or even seized those opportunities by asserting a more defined role for themselves, their contribution was determined by their individual drive and agenda. It was not facilitated by the communication structure and agenda of the therapist within the identified structure. If patients were active in seeking information or treatment choice, the response to this by the physiotherapist was not necessarily to shift their position, but rather to continue with the therapeutic agenda, to provide more information or more explanation but not necessarily to shift ground or accommodate a different role for the patient.

Whilst the ethical principle of beneficence was evident within the interaction, respect for patients’ autonomy was not an obvious underlying basis of the interaction. Although the focus of the analysis of therapists’ communication in this chapter was not on the informed consent process, per se the nature and structure of the interaction appeared to be a constraining framework to the goals of an ‘ethically enriched’ process of informed consent. That is, it was more aligned with achieving outcomes of physical benefit, than respecting a patient’s autonomy. Benefiting the patient through a physical or advisory intervention was valued rather than respecting their autonomy or autonomous choices. The main consequence of this type of interaction for obtaining
informed consent from an ‘ethically enriched’ basis is a type of structural barrier to the ideas of autonomy and shared patient contribution which is built into the clinical discourse.

In the next chapter, I move behind the more obvious structure of therapists’ communication evidenced by the phases of communicative action and content, to examine the dynamic nature of the patient/therapist interaction as a whole.
CHAPTER 7: Roles of the physiotherapist: Balancing expertise and responsiveness

Introduction

In chapter six, I described the overall structural framework of therapists’ clinical communication, a framework which emerged through my analysis of the patterns, content and the overall purpose of therapists’ clinical communication. I demonstrated how therapists gathered and disclosed information grounded in a bio-medical frame of reference, to assess and treat the physical needs of their patient. I also highlighted how they picked up information about their patient’s individual psychological and social needs by providing breaks or opportunities in the structure of the treatment for the patient to tell them about broader aspects of their problem. Importantly, whilst the breaks represented opportunities for increased patient contribution, they were not always recognized and therefore utilised in this way.

In this chapter I build a further layer of understanding or interpretation on this structural framework of clinical communicative practice. Based on this examination, I describe ideals of practice defined by therapists during the in-depth interviews. These ideals comprise the therapists’ role in the interaction, the value of patient trust and notions of good physiotherapy practice. I identify in therapists’ communication a discourse of both ‘expertise’ and ‘responsiveness.’

The first part of this chapter is concerned with how individual therapists’ interpretation of their role as clinical therapists, including their conceptions and understanding of physiotherapy practice, influence their clinical communication. This section of the chapter is based on the interviews with therapists, following the audio-taped treatments. My assumption in presenting this material is that therapists’ opinions, beliefs and values frame and guide their clinical practice. On this basis I refer to the results in this section as therapists’ ‘ideals of practice’.

In the second part of the chapter, I return to the audio-taped treatment data and discuss therapists’ strategies of communication within the clinical encounter. This analysis is aimed at a deeper level than in the previous chapter, where the focus was primarily on describing the content and structure of therapists’ words and language. In this chapter, my aim is to provide a more detailed account of therapists’ interactive strategies, to identify key features.
of the communicative interaction. This analysis corresponds to the analytic step of axial coding.¹ In chapter five I described this step as one of re-examining initial categories of the type of information therapists disclosed to their patients. The analytic questions proposed to guide this stage of the grounded theory analysis included:

- What is the nature of clinical communication?
- What do therapists’ actions take for granted?
- What communicative process is at issue?
- What are the implications of these communicative processes for patients’ contributions?
- What ideals and assumptions underpin the types of information given to patients?’

Each of these questions was used to guide my analysis and discussion of therapists’ communication in this chapter. In the final section of the chapter, I discuss the links between therapists’ individual and collective ‘ideals of practice’ and their individual and collective communication strategies within practice.

The chapter concludes with a return to the research theme. That is to examine the implications of both therapists’ conceptions of practice ideals and their communication strategies on patients’ opportunities and abilities to contribute their voice to the clinical encounter. The two key features of an ‘ethically enriched’ informed consent process, which will inform this final discussion, are the amount and type of patients’ active contribution (that is, the identification of the patient’s voice), and the way therapists facilitate the patient’s contribution. The concluding section highlights that whilst the focus and methods of therapists’ interaction with their patients contains some elements of the necessary framework required for patient autonomy to flourish, their dominant orientation is to achieve a therapeutic outcome and to authoritatively make clinical decisions. I contend that this focus acts to inhibit ethical ideals and conditions of patient autonomy necessary for a deeper understanding and an ability to act on that understanding to obtain patients’ (‘ethically enriched’) informed consent to treatment.

Ideals of practice

In this section I construct a picture of therapists’ ‘ideals of practice’ built from their descriptions of the therapeutic relationship and the respective roles of therapists and patients within the clinical encounter. The picture details who makes clinical decisions, how decisions are influenced by therapist certainty and uncertainty, how therapists use their intuition or personal professional judgment and how they categorise different ‘types of patients’. The picture of practice painted by participating therapists provides background empirical information against which the ideals of ethical and legal theory discussed in earlier chapters may be contrasted.

The occurrence, value and significance of informed consent, whilst being related to therapists’ constructions of practice ideals, roles and relationships was raised as a separate topic in the interviews and is discussed as a separate theme in the next chapter. During the interviews, I asked therapists about the specific information they gave to patients, why they thought it was important and whether gaining their patients’ informed consent was a significant aspect of the treatment. Those questions led to broader questions about the nature of the physiotherapist/patient relationship and the roles of the physiotherapist and patient. It is these broader issues to which I will refer in the sections below.

Therapists talked of the value of and need for patient trust within the therapeutic relationship, the significance of building rapport and the specific roles for both themselves and their patient that flow from such clinical practice ideals. They discussed how they based their decisions regarding what information to communicate to patients on the nature of the patient’s injury, their certainty or lack of certainty as to the diagnosis, their assumptions about the patients’ ability to understand the information and their interpretation of the effect the information might have on the therapeutic outcome.

Building rapport

When therapists were asked about what was important to them in their communication with their patients one of the strongest themes to arise was the significance of building patient rapport. Therapists’ sense and construction of rapport centred around the instrumental value of rapport. That is how it potentially affected the treatment outcome, including their ability to successfully implement an effective treatment.
A sense of rapport between therapists and their patients was seen as instrumentally valuable to the smooth flow of the treatment because it facilitated the achievement of a good therapeutic outcome. The ability to build rapport was defined as both a conscious and unconscious skill. In the following quote, Vera (T13) identifies the skill of building patient rapport leading to a better therapeutic outcome as innate or unconsciously applied. She is referring to other physiotherapists previously employed in her business:

I have some physios who just go in there and within months they are full because they’ve generated that return business. And somehow they get the confidence and rapport of the patient who will send their mother or sister or you know and say things like this physio knows what they’re doing. And then with others it doesn’t come naturally to them and they have to, it might be that it’s just got nothing to do with their skills. Keeping patients interested isn’t always related to how much knowledge and skills they have.

Vera – T13 – 97

Catriona (T10) articulates the importance of rapport and the conscious decision she makes to establish a good relationship based on a comfortable rapport between herself and her patient.

I guess I try and work out what, what’s the language that the patient uses and I try to speak on their level. Like, some people are more educated than others so I try and speak on the patient’s level. I don’t really mean their IQ level but just on their, on the way they speak. So I try and do that which is kind of almost fun, almost a challenge to work out how.

Catriona – T10 – 5

Catriona further explains that the value of rapport is in the effect it has in motivating the patient to follow through with an exercise routine such as attendance at Pilates classes (which involve a commitment to a series of exercises to increase body awareness and trunk muscle strength and stability):

It’s important to make friends with the patient well for two reasons – I guess if they like me they’re more likely to want to hang out with me because the pilates is an ongoing thing so I need them to enjoy coming in here because it’s hard enough to get people to motivate themselves to come in and do it. And I also just think people relax more when they feel like, you know, you’re on their wavelength.

Catriona – T10 – 8

Linda’s (T15) view of building rapport was similar, although she described it as being related to building loyalty:

Because they come to see you and so you have to give them a little bit of what they want otherwise they won’t really establish any rapport with you and they will go and see somebody else.

Linda – T15 – 19
Tom (T1) talked about rapport being valuable because it facilitated the implementation of his treatment strategy and it helped in general, to ensure patient co-operation and motivation to participate in the treatment. In addition, rapport was easier to build when the treatment was successful and good rapport meant that there was less need for more formal explanations or processes of informed consent.

I guess (pause) when you feel comfortable with someone and you've developed a rapport, and I guess you developed a bit of a treatment strategy and you're not sort of swaying then there's not, a lot of it flows quite naturally without necessarily verbal "this is what I'm going to do", "are you ok with that", "is there anything you sort of like or dislike what I've just done?"

Tom – T1 – 15

A sense of familiarity and rapport allowed therapists to comfortably follow their routine treatment and on this basis several therapists chose first time patients for this research because they presumed there would be greater opportunities for a more formal exchange between themselves and their patients. For example, Ray suggests below that familiarity and rapport may inhibit more formal exchanges of information:

With repeat patients “the tape would be full of what they did on the weekend or what I did or I do on the weekend and I suppose the actual conversation related to treatment becomes a smaller part of the treatment session, the more you see a person. You ask them at the start how they've been and you’ll give them a few instructions at the end but the actual treatment session is to do with everything but what you are actually doing”.

Ray – T8 – 92

In all treatments, there was a sense of therapists striving to connect or build rapport in some way with their patients, although as will be discussed later in this chapter, the strategies mostly involved making connections through therapists demonstrating trustworthy and beneficent authority to their patients, and their patients in turn accepting such connections. The idea of rapport was important in its ability to facilitate congruence between patient satisfaction (expressed as their implicit agreement with a proposed treatment plan) and therapists’ expressed aims and treatment plans. The congruence was not achieved through an equal meeting or knowledge of both therapists’ and patients’ aims and objectives, but rather depended on the therapist establishing or smoothing a path which allowed them to implement their goals with the co-operation of their patient. This sense of rapport was thus based upon its instrumental value for the therapist rather than the expressed values of the patient. It relied on the patient trusting the therapist or at least acquiescing to their clinical judgment.
Valuing trust

Like rapport, therapists spoke about trust as an instrumental component of a good physiotherapeutic relationship. They characterised a ‘good’ patient/therapist relationship as one that involved a sense of trust; that is, trust by the patient in the therapist’s expertise. Therapists’ conceptions of the need for and type of trust that patients should have in them was pivotal in their views about clinical decision-making and what constitutes good physiotherapy practice. For example, Vera (T13) saw trust as a defining component of the therapeutic relationship:

> The defining thing about a physiotherapist/patient relationship is the degree of trust between you and the patient and that the patient expects you to have their best interests at heart.

Vera – T13 – 85

In the quote below, Vera further expresses how patient trust, earned by a therapist’s motives of acting in the best interests of the patient, is both valuable to the relationship, and a distinguishing feature of physiotherapy from other allied health professions:

> I think it's that (pause) because it's that they have a trust in you that they expect that you understand their condition, that you've got their best interests in mind. I think we spend a lot of, we spend more time and often, you know...a lot more time to talk about things with patients, compared to some other health professionals.

Vera – T13 – 86

Although other therapists did not discuss patient trust and the idea of therapists acting in the best interests of patients as a defining action compared to other allied health professions, the idea of therapists being hard working and deserving of their patients’ trust is found in other studies and commentaries about the ethos of physiotherapy practice.² Vera went on to suggest that trust is worth working for in the therapeutic encounter because of its instrumental value in maintaining patient interest and motivation to return for treatment, or as Linda (T15) suggested above, building loyalty:

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² Cromie, J., Robertson, V., & Best, M. (2003). In their study of physiotherapists’ descriptions of suffering a work related injury, one of the key frustrations outlined by the therapists was an inability to complete their tasks and build strong relationships with their patients. See also Stiller, C. (2000).
Yeah, getting their confidence. I think a lot of the time we have to sell ourselves, sell you know, why someone needs this and why someone needs to come back sometimes.

Vera – T13 – 87

Rogers and Braunack-Mayer discuss the nature and significance of trust in the general practitioner/patient relationship.³ They define trust as a type of optimism about the person trusted, based on respect for their competency, motives and goodwill. They suggest that trust, and where it lies, is related to the balance of power within a relationship.⁴ These authors describe the general implications of trusting another person in the following five ways:⁵

1. Trusting in someone implies trusting their capability of taking responsibility for their decisions.
2. Trusting in someone implies respect for their autonomy because of the recognition of both their individuality and capacities inherent in trust.
3. Trusting in someone may in fact increase their trustworthiness by positively influencing their behaviour as a trusted person.
4. Trusting in someone affects the balance of power between the trusted and the trustee.
5. Trusting in someone creates opportunities for that person to exercise autonomy to obtain a sense of individual control.

The most significant aspect of therapists’ definitions and explanation of trust was its direction rather than its meaning. By direction, I mean who should trust whom. Therapists worked at gaining the patients’ trust in them as the treating therapist. However, they did not discuss trust in the reverse direction, that is the importance of or the need for the therapist to trust the patient. Therapists’ discussion of the importance of patient trust and the related concept of building rapport meant that the five implications of trusting another person, listed above, flowed in their direction.

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Taking the first of those implications, therapists expected to take on the responsibility of making clinical decisions. They recognized that task as part of their role as the treating therapist. As Craig (T12) states:

I think patients they’re here to see me because they hope that I know something they don’t. So that I can provide them with information and things to do that will help their problem get better.

Craig – T12 – 55

Braunack-Mayer and Roger’s second point specifically relates trust to respect for autonomy. Catriona (T10) succinctly demonstrates this same expectation by stating:

Oh look, I think there are heaps of different options but within the one practitioner there is probably only one. Like that’s the way I saw best to treat her. Someone else here would have seen different and would have done something different – which we are always laughing about how we all approach things so differently but in terms of from the one practitioner, probably there is only one way you think is the best from your experience.

Catriona – T10 – 87

In this excerpt, there is a clear expectation that the patient will take the physiotherapist as he or she finds them and will respect their individual style of treatment and autonomy of decision-making.

Having the trust of the patient was crucial to therapists providing beneficial care, or as the third point above suggests, therapists trustworthiness as the provider of care increased when patients were satisfied with and by implication trusted the therapists’ work. The fourth and fifth points above are similar insofar as they both suggest that trust is significant because it bestows autonomous control and individual power to the person receiving the trust. Therapists in this study discussed trust from the perspective of how the trust of the patient liberates them to follow their own treatment course or as the fifth implication of trust above suggests, the trust of the patient enabled the therapist to act autonomously as a professional.

A consequence of this unidirectional view of the position of trust between therapists and their patients was that a successful treatment which involved a sense of rapport, familiarity and patient trust increased the ability of the therapist to follow their treatment agenda and decreased the need for procedural and formal notions of informed consent or the need for explanation in general. That is, the implications of trust in a relationship listed above flow to the therapists, and as a consequence inhibit a sense of power, autonomy, individuality and control in the patient.
Therapists’ views of trust in the relationship also paved the way for them to make their own decisions about treatment, without necessarily needing to check with their patients. Therapists were able to use their clinical judgment, their experience and their intuition in their clinical decision-making. In the next section, I discuss how therapists intuitively or subjectively recognised what was in the best interests of their patients and made clinical decisions accordingly.

*Therapist Intuition*

Therapists used a type of intuitive reasoning or personal subjective judgment to determine their treatment aims and objectives, how much and what type of information to give to their patient and how effective the treatment was likely to be. By intuitive reasoning, I am referring to therapists’ clinical decisions made on the basis of their subjective judgments of aspects of the patients’ personality, including their impressions of their patients’ ability to tolerate, understand and/or comply with proposed treatments. Therapists interpreted the information needs of patients indirectly and rarely explicitly confirmed their opinion with the patient. They picked up cues by watching, listening and conversing, but rarely by directly asking or checking with the patient. The strategies of watching, listening and interpreting patients’ reactions and responses was mostly incorporated into the clinical communication framework defined and controlled by therapists themselves. The following quote from Leon (T6) summarises these main themes:

Ahh (pause) maybe you can judge some parts of their personality just to see what kind of individual they may be, whether they're somebody who is used to trying to help themselves, or identify ways through their subjective examination of helping themselves. Whether they find, for example, there is back pain and they go and manage it pretty well with walking and doing this and this and avoiding sitting. So you can get an idea during your initial time with them. And then there are those who are completely the opposite way, and that would then take some time to...I think you can generally pick it up within the first two sessions, of how compliant they are going to be. Say if you were going to give them some active exercises or, you know, get them to do the appropriate postural thing at home. And that just varies between each patient. Sometimes you might give someone...somebody may not indicate to you that they're going to do it then they might surprise you. But I tend to pick it up initially and then I've got to choose which way to go.

Leon – T6 – (46, 47)

In the following example, Seth (T16) describes how he makes decisions about providing patients with a bell to ring should the electro-therapy (heat therapy) equipment become too hot:
I give them a bell (for heat equipment). but otherwise, and I would rarely test sensations. You know, you have a gut feeling whether they've got a sensitive problem.

Seth – T16 – 34

Therapists’ intuition or perceptiveness about their particular patients’ needs determined how they framed the ‘right amount’ of information and the level of detail. The ‘right’ amount of information was in turn based on its perceived ability to build rapport and ensure the particular patient was able to trust in the therapist’s abilities and judgment.

Rebecca (T5) in the quote below describes how she makes decisions about the type of information she gives to patients, based on her perception of their individual interests or needs:

I would talk to somebody who might be very body aware, very used to taking responsibility for their own body, very differently to somebody who has no body awareness, has no ability to understand what I’m talking about, and I don't think that has to do with culture or money. It seems to be a personality thing.

Rebecca – T5 – 44

Making a similar point to Rebecca above, Linda (T15) discusses how she consciously tailors information given to patients on the basis of her intuitive assessment of the type of patient she is dealing with:

Yeah. It is very much done intuitively I know myself I give far more information to some people than to others and you pick that up with just how much information they give you. You know some people just don’t want to talk about much and they don’t want that much in return they are just happy for things to be quite simple and yet other people when you start mobilising them and sometimes if I haven’t really given them a good explanation they will see this (model of a spine) on the desk and say, so what is it exactly what is going on with my back and I do tend to avoid that bit because sometimes I am worried that you know - we don’t really know exactly what is going on and you feel like the actor has to come out of you - none of us really know why we get pain and I suppose with some people and again it boils down to the people that are scientific in nature, they are fantastic to treat and you can say quite comfortably to them you know we don’t really know it could be this, this, this or this whereas someone who isn’t that way inclined if you said to them you don’t know you know you could lose all confidence in. I mean they want an answer some people want it black and white.

Linda – T15 – 43

There has been considerable interest in the status, role and definition of intuition in nursing practice. Its proponents assert that it is a sophisticated form of reasoning, playing a critical
role in reflective practice. Others have suggested that it is subjective, unmeasurable and therefore unteachable. In studies of physiotherapy practice, Jensen et al. suggest that a component of expertise, defined by a good therapeutic outcome, is the ability of the therapist to respond intuitively to features and patterns of symptomatology and its presentation.

Edwards et al. also show that therapists gather a range of information from a variety of sources, including objective measurement, intuition and perceptive analysis of the patients’ needs. In a study of how physiotherapists communicated with their patients, Thornquist found evidence of therapists’ intuitive abilities to connect with more personal aspects of the patient and significantly, with respect to the result of my study, she found that therapists chose not to make this knowledge available to their patients, and instead demonstrated more objective reasoning.

A common underlying theme in the work particularly of both Edwards et al. and Jensen et al., referred to above, is a concern with exposing or making visible, the intuitive decision-making of expert physiotherapists so as to enhance the teaching and learning opportunities that might flow from this explicit knowledge.

My interest in therapists’ use of intuition and their ability to perceive aspects of the environment, including individual needs and salient aspects of their patients’ personality, differs from these studies. My aim in describing its occurrence is to point to its consequences for patients’ abilities and opportunities to participate in the communicative agenda. I suggest that therapists’ reliance on intuition and perception contributes to particular conditions of communication. These include a tendency to neglect the patients’ view or at least a failure to check whether the patient agrees with the therapists’ ‘summing up’ of their problem and the appropriate treatment. A further consequence of therapists relying on their intuition and subjective judgments about patients’ needs demonstrated in this research, is that patients needed to actively if not assertively state their particular views.
beliefs or concerns to counter the intuitive and ‘behind the scenes’ judgments of the therapist.

My contention in raising the theme of therapist intuition and experiential judgment is that if it does not in fact match the patients’ beliefs, views and desires about treatment, it may potentially act as a barrier to their ability to contribute autonomously within the interaction. In addition, if it does happen to match the patient’s needs, the patient has still been a passive recipient of the decision-making rather than an active and autonomous contributor.

What is apparent in therapists’ discussions and conception of trust, rapport and intuition as elements of a physiotherapeutic relationship, are lines of demarcation between the roles of both the patient and the therapist.

**Therapist and patient roles**

Therapists spoke of several roles of physiotherapists. Based on the discussion above, some of the roles were to be perceptive to patients’ needs, to make friends with their patient and to gain their trust. Other roles included the job of offering a professional service and making clinical decisions. Aligned with the responsibility that accompanies the trust of the patient, they saw their role as making decisions and providing their patients with information about the cause and effect of patients’ problems. Aaron (T3) describes this role as follows:

> I always explain to patients there is usually a cause and effect. It's how that happened. And as a result this was the result. Where in this situation with this young man, he started to get sore there for no particular reason. And he had been playing, he had returned from his successful knee surgery and he has been playing a few games so he was quite good and then suddenly this business started. That's why I said to him look, normally we have a cause and effect and here we've got an effect - what's the cause? Which made it hard for me to give him prevention. Most of the time I try to formulate at least a possible hypothesis how they got there so at least we give them some sort of prevention.

Aaron – T3 – 14

Therapists also defined their role as offering a professional service. As Joseph (T14) describes below, the role to provide a service is more important than an understanding or commitment to patient choice.11

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11 The theme about the need for patient choice is further developed in chapter eight.
Patients walk in and expect that they are to be given a professional diagnosis or treatment and I think that’s my understanding. That’s usually commonly accepted by patients so that’s why I haven’t thought about, you know, your question about how the patient makes a choice.

Joseph – T14 – 44, 45

Therapists also spoke of their role to empower patients by giving them exercises and activities that they can do for themselves. The following three examples all emphasise the importance of giving patients exercises or information that facilitate them being able to manage their problem themselves. Linda (T15) suggests it is important even though it may result in patients not needing to come back for treatment as often. That is, it encourages independence and active management on the part of the patient. Leon (T6) recognises that self management strategies in the form of giving patients exercises is an increasingly important component of physiotherapy education. The third quote below from Vera suggests that giving patients self-management strategies is tied up with giving the most beneficial treatment and giving the patient value for money:

Very few physiotherapists here would ever not tell someone a home exercise, whether that’s a stretch or a postural strength exercise or something and that’s what it’s about. And at the end of the day you don’t get as much repeat business from that.

Linda – T15 – 71

As an undergraduate, I found that there was a lot of emphasis put on giving exercises, so therefore giving self management. Especially in fourth year, and then when I started off and I felt that I did that a fair bit but I remember then when I was working in the hospital system and I’d be supervising students, it seemed to be even more so that the treatment from the physio would be exercise rather than manual treatment. So, I think there is a fair emphasis on it and that's where I would have learnt it initially.

Leon – T6 – 43

I find that personally I would be in that higher bracket of trying to give patients things to do on their own to take some control of it, to self manage. And I love it when I can give them an exercise that they can do that helps themselves so they don't have to keep coming back in here. I think I formed that view initially when I started private practice, probably because I was, you know, trying to justify whether or not, you know, I was concerned about the money they were spending to come here so I tried to get them better as quickly as possible and let them help themselves. But I still do try to give them something to go on with. Independently, so they don't become dependent here. I don't enjoy treating people, and seeing people, you know, many many times and if I know they can be helped by doing the things themselves at home and they're not doing it then I'll try and call that as early as I can and generally cease treatment.

Vera – T13 – 45

On its surface, the role of empowering patients is close to the idea of giving patients a degree of autonomy. However, as the above quotes demonstrate, therapists’ views about empowering patients were really about giving them strategies to follow or a treatment
program that they could complete in their own time. Information that empowered patients was interpreted as information that enhanced their understanding of the treatment, so that they could recognise its relevance and benefits to them.

The idea of empowering patients expressed within a discourse of ‘patient self management’ has resonance with recent physiotherapy literature. Within the physiotherapy literature, the importance of therapists encouraging patients to self-treat their problems, so as to decrease reliance on passive therapy has been recognised.\(^\text{12}\) In particular in the treatment of chronic pain (which is known to encompass behavioural and cognitive components not appropriately treated by physical modalities),\(^\text{13}\) there has been increasing interest in the physiotherapy literature on the recognition and promotion of patient involvement and understanding of their pain mechanisms from a cognitive and behavioural perspective.\(^\text{14}\) In this respect, self-management is aligned with achieving the best therapeutic outcomes, given the evidence about the neuro-physiological nature of the patient’s problem.

What is significant from the perspective of this research is that the studies which promote patient self management do not encompass or discuss any moral significance of patient self management strategies. Their focus is on the potential physical and otherwise therapeutic benefit of patients managing their condition.

In their discussion of their roles and treatment goals in promoting patient self-management in this study, therapists similarly did not extend the idea of empowering patients to encompass its basis in ethical theories of patient autonomy. Their focus was on how patients could best be given opportunities to manage their problem so as to achieve the best therapeutic outcome. Whilst therapists were aware of the need to involve patients and to give them a greater role in the treatment, they did not seem to have the clinical language or framework of knowledge to include patients as autonomous ‘others’. I argue that this

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conception is not the same as recognising the patients’ autonomous ability to individually reason about the relevance of the treatment, to recognise that patients may have different views about the treatment or to recognise the importance of asking the patients about their beliefs, desires or motivations, regarding treatment proposals.

An important consequence of the different roles (or positions) that physiotherapists described for themselves is the complementary roles that patients must necessarily play. They include being co-operative and compliant, spiced with some interest and a willingness to learn about their problem. The role of empowering patients to manage their own problem, and the roles of therapists to make decisions and patients to comply with them was also reflected in therapists’ description of what constitutes good physiotherapy practice and their characterisations of ‘good’ and ‘difficult’ patients.

**Good physiotherapy practice**

Therapists defined good physiotherapy practice with reference to skills of assessment and patient self-management strategies, including patient education. For example, Jean (T4) defines good physiotherapy treatment by referring to objectivity, giving a patient self-management strategies and ensuring reassessment occurs:

> A good subjective history and objective history, having objective things to reassess. Have a lot of explanation about what you are doing and what you are hoping to achieve, why you are doing it. Sending the patient away with some things that they can work on to improve it and if not giving them a program on the first day, telling that you will be hoping to introduce self management strategies and reassessing at the end of, or after an intervention. Maybe not every intervention, I tend to reassess at the end of the session because it’s too time consuming.

Jean – T4 – 23

Adam (T11) stressed the need for problem-solving skills and a degree of confidence and certainty displayed by the therapist:

> Well, they’re coming to you for a reason and because they’ve come to you because they’ve got a problem they want you to solve or want you to help solve it and if you go to a patient, well what do you want to do, they’ll go well, hang on, that’s why I’ve come here to see you and I just think that, umm, they become confused and sometimes they lose confidence or else they’ll, well it doesn’t really matter what we do.

Adam – T11 – 23

These features of good physiotherapy practice were also present in therapists’ characterisations of easy and difficult patients. Table 7-1 provides examples of therapists’
classification or categorisation of their patients. Patients were classified as good or easy if they tuned into and had an understanding of the main problem, wanted to help themselves, were willing to take on board the physiotherapist’s program and were, as Ray (T8) suggested, ‘intelligent middle class and private patients’. Interestingly, Leon’s (T6) characterisation of a good patient included patients who were anxious and apprehensive because they were easier to deal with and help rather than patients who were too enthusiastic and independent. Patients were regarded as good if their symptoms and problems were straightforward and if they were able to give accurate histories and understand the questions put by the therapist.

They were ‘difficult’ if they could not follow the questioning of the physiotherapist, had little understanding of what information the physiotherapist needed to solve or treat their problem, were too passive or, if they had a preconceived idea of what was wrong, gave too much or irrelevant (in the view of the therapist) information, or were perceived again, according to the treating therapist, as ‘difficult to change’ because of entrenched views.

**Table 7-1: Therapists’ characterisations of good patients**

<table>
<thead>
<tr>
<th>A good patient</th>
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</thead>
<tbody>
<tr>
<td>The role of the patient is to be accepting and happy to he helped (Linda - T15 – 128).</td>
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<tr>
<td>He is actually quite good with his home exercise program. He is kind of the ideal patient, follows</td>
</tr>
<tr>
<td>exactly what he has to do and like, people that you give home exercise programs to, he would be the</td>
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<tr>
<td>type of person who follows it right to the last dot. (Aaron – T3 –6)</td>
</tr>
<tr>
<td>I prefer patients to actually ask me questions and get really involved rather than just be passive</td>
</tr>
<tr>
<td>and just accept the treatments (Ian – T7 – 48).</td>
</tr>
<tr>
<td>Oh, a very good patient. Yeah, he's an intelligent person who wants to help himself (Ray – T8 – 21)</td>
</tr>
<tr>
<td>Yeah I mean sometimes it’s easy because even with this fellow it is quite easy because I said that</td>
</tr>
<tr>
<td>he came in and he wanted a couple of things. He wanted an explanation as to why he had a flare up</td>
</tr>
<tr>
<td>and between the two of us we worked that out and then what he could do about that in terms of what</td>
</tr>
<tr>
<td>he could take away and patients like that are really easy because they come in and they are not</td>
</tr>
<tr>
<td>expecting as much stuff from you more they are expecting explanations and advice and then they have</td>
</tr>
<tr>
<td>to go away and do whatever you tell them to do. (Linda – T15 – 135)</td>
</tr>
<tr>
<td>Sometimes I really like the challenge of somebody who comes in very anxious and apprehensive and</td>
</tr>
<tr>
<td>fearful and… So now three weeks into the self management program, you know, she has got a huge smile</td>
</tr>
<tr>
<td>on her face. Very happy and… so I really enjoy the challenge of those patients (Leon – T6 – 51).</td>
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</tbody>
</table>
Table 7-2: Therapists’ characterisations of difficult patients

<table>
<thead>
<tr>
<th>A difficult patient</th>
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<tbody>
<tr>
<td>A difficult patient will want something that goes against what you know the patient needs. But they might just want the quick fix, they don't want to do any long term or to change their posture or do any exercises. So they can be difficult because they, you sort of almost go against what you know that patient needs (Linda-15-82).</td>
</tr>
<tr>
<td>A difficult patient is the sort of person that is very passive, um… well there are two types. There's the ones whose answers are extremely poor, um… they don't tell you very much. And there's the other type where they tell you everything but what you want to know. And there's plenty of them. A bad patient is the sort of person who wants you to be the sole cure for their problem and they don't really want to have any self involvement (Ray – T8 -78).</td>
</tr>
<tr>
<td>Oh ok. Um yeah well difficult patients are people that have difficult problems where they might have had multiple health problems multiple chronic problems. They have seen lots of therapists and they keep hunting for some sort of cure and they think you will be able to provide for them or, they are quite passive and they are not terribly empowered to do something themselves they are just wanting you to do something to them rather then to do something together to work out the best solution (Leon-T6-10).</td>
</tr>
<tr>
<td>A difficult patient is somebody who has no concept about what the question is that I'm asking. I think that that is the basic. That you ask 'how did you hurt your ankle?' and they'll tell you about their afternoon walk or … you think that a calf injury is related to the walk and it's completely irrelevant and it's really... the answers to questions you've asked (Rebecca – T5 –13).</td>
</tr>
<tr>
<td>Um, and I guess she almost… she was one of those patients that I class from the category, she had a preconceived sort of idea of what was wrong with her and it was difficult to change that, or just to sort of assess her and educate her about what might actually be wrong with her that's different from her idea. (Ian – T7 –10)</td>
</tr>
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</table>

What is significant about therapists’ judgments about good and difficult patients is that they reflect and are based on the notion of the role of the physiotherapist as the ‘expert’, the ‘decision-maker’ and the ‘problem solver’. As a logical consequence, patients who do not assist physiotherapists to achieve this are ‘difficult’.\(^\text{15}\)

Summary of ideals of practice

In chapter six, I demonstrated that the overall structure and content of therapists’ communication was oriented towards getting a job done, and achieving a therapeutic outcome. In the first half of this chapter, I have also shown that the ideals of practice expressed by therapists are similarly oriented. The significant point that should be made at this time is that both the communication structure and therapist’s individually framed ideals of practice reflect the broader culture and ethos of physiotherapy practice described in the

\(^{15}\) See discussion in Potter, M., Gordon, S., & Hamer, P. (2003). Identifying Physiotherapist and Patient Expectations in Private Practice Physiotherapy. *Physiotherapy Canada*, 55, 195-202. In this study the authors found that therapists expected their patients to show them respect and trust, be punctual and compliant and take an active role in rehabilitation. In contrast, patients’ expectations related to ‘hands on’ treatment and symptomatic relief. The authors concluded that therapists needed to more actively identify patient expectations and to match therapist and patient agendas to optimize treatment effectiveness.
professional practice literature. In other words, my analysis of the micro-context of the clinical interaction thus far has resonance with the broader macro-culture of physiotherapy practice.

There was also a consistency in the underlying values guiding practice and the ways of practicing. For example, the ethical framework apparent in therapists’ ‘ideals of practice’ was one of beneficent care. Their descriptions of what constitutes good practice were underpinned by an obligation to do the right thing by the patient. Importantly, in the context of this enquiry, the alternative framework of respecting patient autonomy was less clear and was interpreted more as a duty to provide information enabling the patient to understand the therapist’s therapeutic framework.

In the second half of this chapter, I return to the treatment transcript data and focus again on therapists’ communication. As stated in the introduction to this chapter, the rationale for presentation of therapists’ perceptions of the therapeutic relationship, how they understand their role and the role of the patient, and their ideals of practice, is that therapists’ interpretation potentially influences their communicative strategies and responses within the treatment.

**Strategies of communication**

Therapists used two main strategies of communication to achieve the dual and related aims of achieving a therapeutic outcome and enhancing patient trust and co-operation. The first I have termed the ‘discourse of expertise’. Through this discourse, therapists conveyed authority, objectivity and expertise through their choice of language. The second, I have termed a ‘discourse of responsiveness’ and it was demonstrated by therapists being responsive and perceptive to patients’ stated and unstated needs within the interaction. Both these overall strategies of communication were influenced by therapists’ awareness and sensitivity to the patient within the interaction. However, what was also evident was the thread of consistency that linked their style of communication with their beliefs and values concerning goals of treatment, the nature of the physiotherapeutic relationship and the roles of patient and therapists within such a relationship.

16 See for example Stiller, C. (2000); Cromie, J., Robertson, V., & Best, M. (2003), discussed in chapter four.
In the remaining half of this chapter, I discuss therapists’ strategies of clinical communication according to this overall division of expressing authority and/or being responsive. The discussion aims to provide a more conceptual explanation of therapists’ communicative practices, one that will enable a comparison with the conceptual ideals of autonomy underpinning the process of informed consent.

**Discourse of expertise**

Through their communication, therapists demonstrated their role as the primary decision maker by authoritatively and transparently conveying clinical knowledge. Whilst some explicitly discussed links between their assessment findings, the nature of the problem, the proposed treatment and background information about their knowledge, experience and usual practice, others asserted their authority more implicitly by making unilateral or management decisions without accompanying explanations as to their reasoning. Combinations of these strategies of communication were evident within single treatments in addition to being common to all of the audio-taped treatments. As will be demonstrated below, some therapists tended to be more transparent with their reasoning, that is, to give more clinical information and justification for their treatment, and others seemed to work on the assumption that their role was to make decisions for the patient without accompanying justification.

Within the ‘discourse of expertise’ the ‘explicit reasoning’ strategy assumed the patient could and would be won over by their logic and breadth and depth of reasoning. The ‘implicit reasoning’ strategy relied more on patients’ trust and faith in the therapist’s expertise.

The following two quotes provide examples of therapists making explicit links in their reasoning. In the first quote, Aaron (T3) gives the patient information and explanatory links about his main concern being the difference in feel between sides in the lumbar spine. In the second quote, Ray (T8) gives his patient information that relates the amount of swelling to the extent of the injury:

Cos this is the one that worries me. Right there. L4-L5. Just there. That’s the only one. Feels different compared to the other side.

Aaron – T3 – 169
You don't really have much in the way of swelling. You'd call this a grade two sprain because... a grade one is just a stretch but without any tearing

Ray – T8 – 149

A feature of these quotes is the verbalisation of the therapists’ clinical reasoning strategies and their demonstration of an underlying deductive and logical problem solving approach to treatment, where problems are both implicitly and explicitly linked to physical causes. For example, Aaron (T3) again explains the reasoning behind the treatment in the following example by specifically linking the treatment approach to the assessment:

So what I’m going to do...move it for a few seconds. Then I’ll get you up and re-check, and see if that makes any difference to symptoms that you gave and the way you were getting the pain.

Aaron – T3 – 169

Karen (T2) similarly explicitly provides reasons for her assessment, in this case of her patient’s big toe and reasons for why it might have been injured:

So you are a bit stiff in your big toe. The reason I am having a look at that is because this one feels bad...when you are rising up onto the point on the left, you just actually find a little knot in the big toe? When you are on the right side you were rolling onto the big toe. The reason you are probably doing that is because of that big toe stiffness...so I’m going to give you a stretch for that big toe

Karen – T2 – 212

At times, (and within one treatment), therapists broadened the explanatory links from the language of body sensations to the patient’s work and lifestyle. At other times, they narrowed the explanation to physiological or anatomical terms. For example, in the two excerpts from Ian’s treatment below, he begins by explaining the nature of the treatment and the need for assessment following treatment. He then warns of the possibility of treatment soreness following the treatment. When the patient asks for more detail about the treatment effect, Peter then includes the possibility of other contributing factors that may affect her back pain:

All right. So, I'm just going to mobilize, so just pressing on your joints, just try and loosen them up a bit. And when we've finished this we'll actually reassess your movements to see if you've got any more movement.

So you may feel a bit of soreness...tonight, from what I've been doing. So, different to what you've been feeling...just from the joint mobilizing, which is quite normal.

So, you think it might be extra stiff in the morning?
Yeah. (long pause) So have a look at your pilates exercises. And your swimming if you can fit it in and dancing. Your activities, as well as looking at your...umm...you know, making sure you are sitting with good posture at work.

Ian – T7 – (151-153)

The significance of Ian’s example is that it demonstrates how therapists formulate the language of the problem. Even where the possibility of multiple influences was presented by the patient, the formulation of those influences and uncertainties was clearly the work of the therapist. This is also apparent in the following example, where despite the patient’s efforts to find some reasons for his problem, Aaron (T3) seemed intent on coming up with his own explanation and reasoning:

Look... it could have been anything. It could have been the way you kicked, it could have been the way you sprinted.

We didn’t even kick the ball.

It could have even been at work.

I’m not working. (laugh) But I know what you mean, it could have been anything yeah.

I don’t know. It could be the drive to work, it could be the way you slept, I mean it’s odd because you didn’t feel any symptoms in the morning, it was just at training.

Aaron – T3 – (361 – 362)

Therapists verbally demonstrated correlations between their diagnosis, suggested management options and likely outcomes. In so doing, they controlled the direction of the discourse and positioned themselves as having the expertise and objective knowledge to solve the patient’s problem. They used information given to them by patients in combination with their objective assessment to describe and delineate the patients’ problems. In the following example, I again refer to Ian (T7) as providing the best examples of a therapist who asserted and displayed clinical authority and expertise. Prior to this quote, Ian had completed his assessment phase of the treatment and was providing his findings to the patient, using both information that he had gathered during the objective physical assessment and information given to him by the patient. His explanation ranged from preventative causes related to poor posture through to less controllable causes such as disc pathology. The patient was not invited to ask any questions or contribute her understanding. If she was asked, it would in any case be difficult to contribute her view, as Ian’s explanation was wide ranging and diffuse:

And doing all that sort of stuff. That's enough to do it to you. Now have a sit down. I think you’re probably right, what's happening is that you haven't been moving as much as normal.
And you've been also probably sitting with your posture bent, like the slump sitting, you were
telling me you spend a lot of time sitting and reading in bed. That's probably going to put a
lot of pressure on the discs of your back and it seems, although it's not really been reproduced
with your movement, physical pain in the morning...that's a sign of sort of pain that's coming
from the discs also...so I think your discs are sort of inflamed a little bit. Ummm, but that's
probably causing that stiffness so your back doesn't want to move. So you've got these - in
here - one disc that's probably not in very good condition and when you bend your back it's
tightening up because of that. Ok? So, I think overall the main thing that you really need to
come into is stiffness.

Ian – T7 – 144

I contend that these examples demonstrate the primary purpose of the therapist adopting an
explicit disclosure approach was not to empower or enable patient contribution, but rather to
maintain a firm control and ownership over the use of their explanations.

The second and less common way that therapists demonstrated their clinical expertise was
by making implicit links in their reasoning processes. Therapists would give information
without any accompanying explanatory links, that is, information which consisted only of
the therapists’ conclusions about their assessment, diagnosis or treatment strategy without
accompanying information as to how the therapist arrived at their decision. The underlying
assumption in these examples is that patients would trust in the therapist’s expertise. For
example, in Rebecca’s (T5) examination of her patient, she asked the following question of
her patient:

Have you got a GP? And who is that? Oh right (pause) I’m only asking the question just in
case I’m not happy with the results today. I might get you to go back to see him for further
investigation.

Rebecca – T5 – 87

Rebecca’s explanation to the patient of why she may need to go back to the doctor was put
in terms of ‘in case I’m not happy with the results’. In the interview with me, following the
treatment, Rebecca explained that the patient’s pain presentation and pattern of symptoms
was very unusual and she was concerned that it might have been a circulation problem,
rather than a calf strain.17

The point to be made in this analysis about Rebecca’s explanation is not whether her clinical
reasoning processes were accurate, but what effect they might have had on the patient’s
ability to autonomously contribute to the encounter. In this particular case, the patient’s

17 In fact this patient’s problem was later diagnosed as a Deep Vein Thrombosis, so Rebecca’s
concerns proved to be well founded.
trust in Rebecca’s judgment was needed during the treatment encounter, that is, to accept Rebecca’s concerns and to act upon them by returning to the doctor, without an explanation as to why that might be needed.

Therapists’ ‘discourse of expertise’ derived from a type of visible problem solving, or hypothesis generation and confirmation process previously discussed in chapter six. In a qualitative study of how physicians make their medical knowledge operational and then decipherable to a patient with chronic pain, Baszanger found a similarly reductionist and authoritative approach by physicians to patients’ signs, symptoms and management options.\(^\text{18}\) The way doctors in this study were shown to make clinical decisions is similar to my analysis of physiotherapists’ communicative practices:

> He (the physician) displays his logic of demonstration by pointing to signs on the body, establishing hypotheses, drawing up a tree diagram of causes, eliminating possibilities and laying down operational rules.\(^\text{19}\)

In chapter three, I referred to Brody’s model of transparency as a way of communicating to patients and fulfilling obligations of informed consent. The way that therapists explicitly provided information to their patients about the treatment process and their processes of clinical reasoning was very similar to Brody’s model of ‘thinking out loud’ as a way of informing and providing explanations to patients. I argued in chapter three and argue in this chapter that although the patient is given information (a crucial step in fulfilling the obligations of obtaining their informed consent), the underlying purpose and strategies of imparting the information is to justify the therapists’ authority and expertise and thereby gain patients’ trust and cooperation, and not to empower or enable patients’ contribution through their consent to treatment. I base this argument on three key findings. First, there was little evidence of therapists explicitly checking patients’ understanding of their explanation. Second, the information or explanation was made available to the patient as an end point or as a final justification or explanation – the end of a sentence. Third, the information was provided as a *fait accompli* rather than as an invitation for the patients to become involved or contribute their view. These three findings all provide examples of therapists thinking aloud. Hence the motivations underlying this transparent way of

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reasoning I suggest, is to primarily demonstrate expertise, rather than to empower the patient.

In the next section, I discuss the second main strategy of communication to arise from the analysis of the treatment data, the ‘discourse of responsiveness’. I discuss the way therapists responded to their patients’ needs and illustrate that therapists were motivated to meet the individual needs of the patients. However, I also demonstrate that what is apparent in therapists’ responsiveness is that it was grounded in beneficence, a desire to do the ‘best for the patient’ and not grounded in the promotion of equal contribution or patient autonomy.

**Discourse of responsiveness**

In this research, the term ‘discourse of responsiveness’ refers to the ability of therapists to both recognise and respond to expanded sources of knowledge, especially individual social or emotional (non-physical) needs of their patients. In a physiotherapy setting, and with reference to ethical ideals of respect for patient autonomy, this means an ability to respond not just to the physical set of symptoms and functional problems. It means also being able to recognise and respond in a dynamic and consistent way to the capacities and abilities that are relevant to a patient’s autonomous contribution and choice.

In the following section, I highlight therapists’ responses that demonstrate a willingness to follow patients’ interests or lead in the interaction. In these responses, there is an overall sense of flexibility and generosity, similar to the idea of structural breaks in the communication discussed in chapter six. The idea of responsiveness differs from structural breaks in that here, I frame and analyse therapists’ responsiveness in the context of the dynamic nature of the interaction rather than as a description of its structure.

Flexibility and responsiveness on the part of the therapists arose from the interaction itself. It consisted of a general willingness to follow the patient’s responses and actively incorporate them into the flow of the treatment. More specifically, it involved the therapist paraphrasing the patient’s contribution to the clinical reasoning process, allowing the patient to contribute to the clinical reasoning through the patient’s own reasoning, or responding to the patients’ concerns, but without explicitly referring to their concerns. Ray (T8) provides an example of this latter response, where he was aware of the patient’s concerns and anxiety about attending physiotherapy for the first time and he decided on a response which used humour (see lines in bold) to make light of the patients’ expression of concern:
All this is new to me. I was a bit nervous coming in

What, you’ve never been to a physio before?

No, never

Yeah...and that’s what a lot of people say...(pause) And you know, it's not quite as medieval as ah...

(laugh)

It depends what you are doing of course

(laugh)

Now, point your toes down as far as you can

Ray – T8 – 55

In this response, Ray was clearly aware of the patient’s concerns and chose to make light of them as a way of responding. The laughter served to shut down discussion of the topic chosen by the patient, namely, his nervousness at attending for treatment. The patient was not asked to provide any further details or clarification of his concerns. There was no explanation of the likely course of the treatment encounter so as to either reassure the patient or to obtain consent to the proposed course to be adopted. The patient was simply not afforded the opportunity to know what was to come, let alone consent to it.

An alternative analysis of this exchange might be that the therapist in recognising some anxiety in the patient effectively reassured the patient by using humour, and a more positive analysis would be that therapists are sensitive to patients’ concerns. My sense in listening to this exchange was that the patient was reassured. However, the exchange nevertheless reinforces the idea raised earlier in this chapter that therapists believed their role to be one of gaining patients’ trust and confidence. In this case, by the use of reassurance infused with humour. Because my analytic interest is framed in terms of opportunities for patients’ autonomous and more equal contribution, then my slant on the exchange is more negative, insofar as I suggest that although Ray appeared to be trying to act beneficiantly, he was nevertheless not actively respecting or enhancing his patient’s autonomy.

The treatments and interviews of four physiotherapists stood out as the clearest examples of what I have termed the ‘discourse of responsiveness’. They were Tom (T1), Jean (T4), Linda (T15) and Leon (T6). These therapists stood out because their approach to their patients was more flexible and less reliant on the formal structure and phases of communication discussed in chapter six.
In Tom’s (T1) treatment, the patient had been several times previously and although she appeared to be reserved in her responses there was a clear sense that she trusted and felt comfortable with Tom. My analysis of the treatment raised several of the themes of responsiveness which became apparent in other treatments. The memo I wrote at the conclusion of listening to Tom’s treatment highlights both the thematic complexity and the importance of therapist responsiveness to the flow and nature of the interaction:

Patient’s opinions, understanding, satisfaction and involvement in their treatment is determined by multiple factors. Some of the factors which are revealed within the communication are determined by the physiotherapist. That is, whether the therapist provides opportunities for the patient to provide their viewpoint or understanding of the problem. This may be done indirectly by the therapist responding to the patient’s expressed lack of certainty or by the therapist following the patient’s responses and probing further. In this communication, there was a sense of give and take although not a sense of patient empowerment in an active way, more a comfortable and generous spirit within the interaction.

Memo after listening to Tom’s treatment

In the particular extract below, the example of responsiveness is quite subtle (see bolded line). Tom acknowledges the patient’s contribution and uses it in his assessment. Tom refers the patient’s stated symptoms back to her previous explanation and in so doing demonstrates an active interest and use of her contributions.

Good. Just take your head forwards and down. Just describe what you are feeling as you do that.

*I can feel pulling in both sides of the back of my neck.*

Point to the spot.

*Through here.*

Yep.

*And there.*

Ok. Just let your head relax and let it drop forwards as far as it wants to.

*Yeah, more on the right side.*

Ok. Taking it back to neutral then working on it through. (long pause)

*I can feel pain in my right shoulder up here.*

**Like the feeling you were getting last night?**

*Yes.*

Ok, bringing it back down to neutral, (pause) Did the pain go away?
The memo I wrote after listening to Linda’s (T15) treatment similarly raises a general sense of flexibility and, at the same time, demonstrates Linda’s ability to paraphrase the patient’s language:

In this treatment, there was much more explanation of what the therapist was thinking about, and much more explicit use of the patient’s information to help inform the therapist. There were less clear divisions of assessment, diagnosis and treatment. Throughout the treatment, there was an on-going dialogue between Liz and her patient about what might be contributing to the problem. The patient also appeared to be articulate insofar as he was able to state his view and to ask for clarification. Liz seemed very aware and responsive to the patient. Her agenda was not as dominant in seeking information.

Memo following Linda’s treatment

In the specific example below, Linda paraphrases or clarifies the patient’s contribution about difficulties in getting in and out of the car (see sentence in bold):

Yeah.

And when it was at its worst it was really an issue to get into the car.

Yes.

But then you sort of, you are not conscious of it until you've got a sore something.

Yes.

Of what you're doing. But when I had (pause) it was really difficult to sort of bend and (pause)

Because you've got to bend so many things at once. You've got to bend your head down and lift your leg up and get into a low seat.

Yes, yes. You're not conscious of that until something is playing up.

Yeah, that's right. So you really noticed that yesterday after you'd done the four hour drive? Ok, anything (pause) what other sort of postures do you notice or movements that have made it worse?

(pause) Oh, I can't say

Linda - T15 – 35

Jean (T4) was another therapist who demonstrated an overriding sense of responsiveness to her patient. Jean had worked as a therapist for twenty-five years and she was the most experienced therapist in this research. Her approach demonstrated a sense of confidence and flexibility. In the specific example of responsiveness below, Jean allows the patient to reach the conclusion (in bold) about what type of mattress she needs after some discussion, rather than Jean dominating the advice and communicative agenda:

And I didn’t get my (pause) um (pause) eggshell mattress.

Right.
My darling husband said “oh, wouldn’t they break”, you know, he didn’t understand what I was talking about (laugh) And I thought you said a foam mattress, did you?

It’s an eggshell foam.

I thought you said foam. Cos I said “Julia you’ve got a foam mattress under” (pause) oh, and so Janet I got that out but it was terrible. I had to get up in the middle of the night and… just an ordinary foam mattress was (pause)

No good?
certainly terrible.

Oh well, that was good to try it. How thick was the foam mattress?

Oh about a normal, a normal foam mattress about six inches I suppose.

Right. And that was on the floor was it?

No that was on top of my bed.

Oh, perhaps that was too soft.

Too soft, oh yeah.

But that is a good way to try it so possibly, I mean I don’t want you to outlay that money if it’s not going to suit your back, I just thought it might be worth trying.

So (pause) I think I need a foam, a firmer surface (pause)

All right.

Because I haven’t bought a... we didn’t buy that um....

No, no. Trial and error. So that’s good, you’ve tried the foam.

Jean – T4 –(127 – 143)

In this exchange, Jean allows the patient to give an account of the steps she took in trying out the mattress and coming to the conclusion that it was too soft.

In all the above specific examples of responsiveness, only minor adjustments of the interaction are made. However I argue that they profoundly alter the tone of the interaction because they allow the patient a more prominent and equal position in the exchange.

The example from Leon (T6) below was the only example of a therapist explicitly seeking the patient’s views and thoughts about a proposed treatment. It was also the only example of a patient presenting with a long term problem where the therapist had developed a defined treatment plan which involved giving guidance and encouragement to the patient to self-manage their problem, rather than being focused on the provision of manual physiotherapy treatment. In this example Leon gave the patient an explicit opportunity to express their thoughts about hydrotherapy and the patient was able to express their plans.

So did you get to start your hydro yet?

No
What are you thinking about that?

_Um, I'm definitely going to start it just not this week. I was going to start it last week but I thought... I'd like to, I'll just go and see Lee for the last time and then I'll go._

Leon – T6 – 77

This example provides a counterpoint to my previous analysis of the more restricted approach to providing opportunities for patients to contribute. However it strengthens the finding that the dominant strategies of communication, where the patient presents with an acute problem, are to impose a therapeutic agenda built on certainty and therapist confidence, rather than to open the agenda to embrace patients’ thoughts and values.

In the examples above, I have highlighted a small number of therapist/patient interactions to demonstrate the theme of responsiveness. What is significant in this group is that there is not a unifying theme concerning the nature of the patients’ problems, therapists’ level of experience or indeed their formal post-graduate education, that might explain why they were more responsive to their individual patients. The one unifying feature in these examples was a commitment to the patient as a person rather than the patient as a ‘type of patient’.

During the interviews, each of the four therapists gave detailed descriptions about their patients and their particular requirements:

She seemed sort of quiet initially, that is the type of character she is. She’s not the sort of person who verbalises a lot... perhaps if you were doing something that she wasn’t that happy with, where wouldn’t necessarily say ‘I’m not happy with that.’ I sort of got the feeling with her that she was that sort of person.

Tom-T1-33

She’s marvellous. She has a heavy load at home, looking after her autistic daughter and her husband. She asked a lot of questions along the way and she was very good at taking things on board.

Jean-T4-8

I don’t think he has a great deal of insight into the whole situation and what everything means. And what I’ve been able to gather from seeing him recently is that he is very confused about his claim situation and his insight into that is a problem for him and just and what work he is going to do. He probably doesn’t understand the implications of everything. Which in a way is maybe good for him and reduces his stress load.

Leon-T6-18

He was very articulate and presented with a clear explanation of his back problem and it was clear that he wanted to be involved in the treatment and that he wanted some exercises to take home. He was a retired builder and he did a lot of driving.

Linda –T15-8
Whilst the ‘discourse of responsiveness’ was aimed at responding to the patients’ individual needs and personality, and depended upon the therapist recognising those individual needs, the response was woven into an overall beneficent approach to the therapeutic outcome. In the previous section, I argued that therapists’ ‘discourse of expertise’ was aimed at achieving a therapeutic outcome by facilitating patient trust, confidence and compliance to therapist-defined outcomes of treatment. Whilst the discourse of responsiveness enriches this goal, it does not alter it. In other words, whilst there was evidence of therapists both acknowledging patients’ views and having an awareness and respect for their patients’ capacities to provide their own interpretation and views, including their opinion about diagnosis and treatment plans, such acknowledgement did not extend to the promotion of the richer notion of autonomy and associated understanding of what might affect a person’s ability to autonomously contribute in a given situation.

The discourse of responsiveness is an important one in the context of this research enquiry because it demonstrates a willingness and an ability to connect with the patient as an autonomous person. This is a broader base of connection than one that is motivated solely by achieving a therapeutic outcome. The therapists who demonstrated this discourse within their clinical communication were also motivated to connect with the patient on broader levels, that is, they made links between the patient’s particular situation and personality and their physically based therapeutic needs. Importantly, those links served to broaden the aims of the therapeutic intervention, to encompass the patient’s perspective. If the purpose of therapists’ responsiveness was to include other aspects of the patient into the goals of the treatment, then it also represents an opportunity to actively promote a patient’s autonomy. The examples in this research did not extend to active promotion of autonomy, but they do demonstrate that there is a framework of communication within clinical communicative practice which lends itself to the ideals of ‘ethically enriched’ informed consent.

Chapter summary and conclusions

In this chapter I have examined therapists’ ‘ideals of practice’ through their explanations of the physiotherapeutic relationship, including the related constructs of patient rapport and trust. Patients’ roles and the boundaries of their involvement were drawn by physiotherapists’ interpretation of patients’ capacities to understand and their characterisation of the type of patient with whom they were dealing. The role of the therapist extended to ensuring the patient understood the purpose and nature of the
treatment, but as will be discussed more fully in the next chapter, the role of the therapist was not recognised as extending to ensure that patients make clinical decisions based on alternate choices or treatment paths or based on an enhancement of their individual capacity to do so.

Therapists’ views of their roles, their characterisations of patients’ roles and their ‘ideals of practice’ have highlighted differences and sources of tension between the values and ideals of physiotherapy practice and the ethical value of patient autonomy. Therapists’ overriding value and goal was to achieve a therapist defined therapeutic outcome facilitated by patient trust and rapport. In contrast, the ethical values that seek to respect patients’ autonomous self determination in the form of enhancing capacities and rights to make autonomous decisions, are less concerned with the therapeutic outcome and more concerned with the quality and nature of the patient’s contribution.

The picture painted by both this chapter and the previous one is of a consistent, methodical and beneficent approach to clinical reasoning and problem solving evident in the clinical communication. If the purpose of this research had been to examine consistency between clinical practice ideals and methods, and theoretical models of clinical reasoning, or the consistency of the clinical communication process, I would conclude that there was indeed consistency and links between theoretical models of clinical reasoning and actual practice. However, the aim of the research is to develop an understanding of the role, interpretation and implementation of informed consent within the clinical physiotherapy encounter. The picture painted of the structure, content, ideals of practice and strategies of communication within the therapeutic encounter suggests that there is a gap between the ideals of autonomy promotion underlying informed consent and the realities of beneficence-based actual practice.

The final findings chapter investigates this gap further by looking specifically at physiotherapists’ understanding and implementation of informed consent.
CHAPTER 8: Clinical communication and informed consent

Introduction

In this final findings chapter, I focus on the process of informed consent from the perspective of how therapists defined informed consent and how they describe its relevance to physiotherapy treatment. The chapter has two aims. First, to describe the place and significance of informed consent in the clinical encounter based on my analysis of both therapists’ explanations of the significance and meaning of informed consent and the communication within the audio-taped clinical encounters. Second, to compare the consequences of therapists’ views about and practices of obtaining informed consent to the ideals of an ‘ethically enriched’ process of informed consent with its associated strong links to the theory of autonomy.

The chapter relies mostly on analysis based on interview data. In the interviews, therapists defined informed consent in two main ways. The most common was that obtaining patients’ consent to treatment was an implicit and everyday part of the structure and aims of their usual clinical communication. The second way was to suggest that informed consent was a purposeful and explicit part of the communication when there was an element of risk associated with the treatment.

Analysis of the treatment audiotapes revealed few instances of a therapist/patient exchange consisting of therapists giving information about a treatment, or choices of alternative treatments to patients, followed by an explicit request for patients’ consent. Even less common were exchanges which consisted of therapists asking the patient about their preferences or values about a proposed treatment.

Decisions as to the amount and type of information to give to a patient and responses to their needs were both informed and limited by an overarching framework (previously discussed in chapter seven) of what constitutes good physiotherapy practice, including the roles that both therapists and patients consequently play in the clinical relationship.

The implications of therapists’ views and practices of obtaining informed consent for their conception of patient autonomy suggests that as an underlying ethical concept, therapists interpreted autonomy as a type of freedom of choice to attend physiotherapy. It did not
include the underlying theoretical constituent parts of personal autonomy such as the possibility of psychological, emotional, environmental and social factors which might impact on a patient’s ability and opportunity to be autonomous in a given clinical situation. The features of an ‘ethically enriched’ informed consent process that I identified included a sense of willingness to accept patients’ contribution to the interaction and a transparent manner of explanation of proposed treatments, including therapists’ clinical justification and associated clinical reasoning.

**Informed consent: a routine part of communication**

Informed consent means letting the patient know exactly what I am about to undertake.

Saul – T9 – 89

When therapists were asked to define the meaning of informed consent, two prominent themes emerged in the analysis. The first reflected in Saul’s statement above was that informed consent was an implicit component of the usual treatment interaction. By implicit, I mean that it was absorbed into therapists’ routine clinical communication such as providing patients with explanations about the proposed treatment. The explanations were based on bio-medically formulated plans and diagnoses, chosen by therapists and not patients.

Therapists described the communicative action of obtaining a patient’s informed consent to treatment as implicitly or informally part of their everyday practice. In so doing, they defined and situated obtaining informed consent as a part of the normal physiotherapy/patient interaction, and at the same time distanced it from more explicit ways of obtaining informed consent. Therapists linked the idea of informed consent to their role to provide explanations to their patients about what they intended to do, and to provide opportunities in the communication for patients to positively agree, to tacitly agree, to not disagree or to provide feedback (about the effects of the treatment). In other words, they equated the provision of information leading to informed consent with explanations of their aims and proposals for treatment, explanations of their clinical reasoning and explanations of how patients should comply with their instructions.

‘Implicit informed consent’ emphasised the ‘informing’ part of informed consent, which was the work of therapists. As the dominant component of their definitions of informed
consent, informing the patient was embedded and entwined in the therapeutic purpose of the communicative discourse, which was to achieve a successful treatment outcome including measurable physical change, and/or patient compliance including active involvement. The following two quotes summarise these main themes. The first is from Linda (T15), who suggests that obtaining informed consent is linked to both patient satisfaction with and understanding of a therapist’s treatment plans. The second is from Catriona (T10) who further narrows the application or need for informed consent to times when extra motivation and input is needed from patients:

Well, I guess it's just the patient having an understanding of the type of treatment you want to do whether that's an exercise or a hands on treatment and being happy for you to do that. And acknowledging that they are happy for you to do that. So a degree of understanding about what it is. And they have to - I mean I don't do written - but they have to at least acknowledge that, yeah you can do that now.

Linda – T15 – 23

I suppose the only time I need to get consent or agreement with patients is if they come in and I think the main thing they need is an exercise program and I have to really explain to them that that is what really is going to help them and they really have to apply themselves to that for the six or ten weeks or whatever and not to expect an improvement unless they do that. I guess this is tied up in the compliance though.

Catriona – T10 – 7

The treatment excerpt from Sean (T17) below illustrates the way therapists described obtaining a patients’ consent to treatment to be based on their explanations. As Sean’s example demonstrates, such explanations contained elements of certainty, confidence, expertise, logical reasoning and beneficent care. For the patient, upon receipt of this information, their role was essentially to agree. In this example, Sean had just completed his assessment of the patient (a 72 year old man with an acute onset of low back pain). Sean asks for the patient’s agreement or consent to the proposed treatment (line in bold). This question is preceded by quite a long explanation of what Sean regards as the patient’s main problem. The explanation mentions ligaments, joints, the impact of his patient’s bricklaying on those structures, a slight tear, the gradual effect of pain, the healing process, the possibility of scar tissue, and the necessary treatment of stretching and mobilising exercises. To all of this his patient responds, “right, yes, uh huh”. Finally, Sean asks, “So that’s my plan. Does that sound reasonable?” to which the patient responds ‘That sounds ok to me’:

Ok, good. Can you just lie on your tummy again? What I think is happening here is you've got a ligament tear. You've got some things called facet joints which go from the very top of the skull down to the bottom. Excuse me for just a second - (answers phone)

Yeah.
Um, you've got these facet joints which...go from here up to here...and between each one of them is a ligament. And...I think what you've done through all that bricklaying was that you basically sprained these ligaments here. You've over-stretched them or there is too much pressure going through them even with the muscle contraction...and you've had a slight tear develop in them. And um...probably um...having done it for a while on and off it's had a gradual effect and then all of a sudden...Thursday's and Friday's efforts were a bit too much. Go past the breaking point, point of no return...

Right.

You get a tear develop in them and then that's where you are getting your pain from now. Part of the healing process, you scar are fairly quickly and you stiffen up very quickly. Ok? Because the tear is laying down scar tissue and it's all part of the body's healing and we need that.

Mmmm, mmmm.

However, that can cause these joints to stiffen up very quickly ok.

Ok.

So, how we remedy that is...that sort of thing that I just did then as an assessment tool, I put my thumbs on here and I pressed down giving pressures up and down. Another way of stretching it out is to sort of rotate you, give you a bit of a twist and a stretch out and then get you to do the same thing at home with some home mobilising exercises.

Ok.

Ok? And possibly then down the track just to give you some strengthening to prevent this sort of thing happening in the future.

So that's my plan. Does that sound reasonable?

That's sounds ok to me

Sean – T17 – 52-63

What is significant about Sean’s long explanation as a build up to asking for his patient’s consent, is the possible effect that this display of expertise and logical reasoning has on the patient’s ability to offer an alternative position or ask about a different treatment option. The patient would have to be quite assertive or at least equally knowledgeable in the same clinical area as Sean to challenge or question Sean’s explanation.

Aligned with the idea of informed consent being a type of education and explanation, therapists also defined the informed consent process as a process of providing information that enabled patients to become more involved in the treatment. An important consequence of this framing of informed consent (as the following four quotes illustrate), is that patients’ involvement was limited to understanding and complying with therapists’ therapeutic plans in order to optimise the likely success of the treatment:

You probably tend to give them...I like to give them enough knowledge so that they can participate actively and understand what's going on and, yeah, hopefully when they are not with you they know what to do and what not to do.
Craig – T12 – 56
Informed consent

I'm very big on getting to the heart of the problem and then explaining it very, very well because I think you get the most out of it then if they understand what's going on

Saul – T9 – 55
No, I don't ask can I have your consent to… but I will explain to the patient what I want to do and why I want to do it and ask them is it ok if I proceed with that

Rebecca – T5 – 19
The best way to get a person’s consent just mainly in general or commonly used treatment is to say I’m going to do this… and try to explain to them what’s the purpose of it.

Joseph – T14 – 14

In both Sean’s long explanation and in the four quotes above, the emphasis in the informed consent process is on the element of information provision. As discussed in chapter seven, therapists were comfortable in this role as providers of information and as the main clinical decision-maker.

Therapists found it difficult to disentangle the act of obtaining a patient’s consent from the clinically focused, intuitive and routine exchange that occurred between themselves and their patient. Tom (T1) explains the connection between obtaining a patient’s informed consent and providing treatment in the following way:

I don't think the boundaries are set clear enough as to what informed consent is (pause) when I stopped and thought about what informed consent is… it's so sort of entwined in what we do that it's not really a clear little subset on its own that you can say, well have I given this person informed consent about everything you do, from the time you walk in the door to the time you walk out. From the time of your assessment, through your treatment then through your advice. It's a part of everything that you do, yeah, every time that you are speaking with the person and they are talking to you, you know, is there sort of (pause) again, what is it, it's difficult to sort of… It is. It's very difficult to study I would imagine.

Tom – T1 – 5

An important consequence of this understanding and placement of informed consent within the content and purpose of clinical communication is that it limits the patient’s role in the informed consent process. The role of the patient is pre-determined by the nature and expectations apparent in the therapists’ strategies of communication. That is, to agree or defer to the expertise of the therapist. On this basis the ‘consent’ component (or the patient’s component), is necessarily a more diluted component than the provision of information component (or the therapist’s component).

In this research, the consent component was in fact mostly subsumed into therapists’ explanations. Therapists assumed that their explanations provided sufficient opportunity for
the patient to be satisfied and implicitly agree with treatment proposals, as both Saul (T9) and Craig (T12) illustrate:

In a general kind of patient I usually explain to them what I think the problem is, what I can do to help, what they can do to help and this is what I'm going to do to treat you. Any concerns? That's in general, most people are pretty happy, they are kind of willing and they go...off we go.

Saul – T9 – 32

Informed consent means the patient understanding what you are doing so they understand why you are doing what you are doing and also that they've got the option to say no if they don't feel comfortable with it basically.

Craig – T12 – 24

The consent component was assessed by therapists as either patient agreement or lack of disagreement rather than an explicit or separate part of the communication, as Joseph (T14) states:

I'll just let them know I'm going to do this and if they don't have any objection or any query I will go ahead.

Joseph – T14 – 29

The following comments from Craig (T12) summarise the notion of patients’ agreement, tacit agreement or lack of disagreement as a source of implicit consent:

I guess all treatment (pause) probably has implication that consent is given. Probably if it's not withheld. Although we don't tend to go through a formal process at all. I mean generally they don’t protest, or they don’t object. And they don’t say, they usually, I guess trust in your expertise when you say, I’m going to do (pause) and I’m going to do a technique that looks like this, they will assume that I know what I’m doing.

Craig – T12 – 9

The way we normally do it, that sort of implied consent, which is probably as close, as we ever get to really having consent when you think about it, is that the patient agrees with what you have to say and away you go. You know, most things we take for granted that the patient has consented, umm (pause) and they don’t actively object.

Craig – T12 – 47

Therapists discussed how and why they made decisions as to when informed consent was necessary based on their clinical reasoning decisions associated with treatment risks and choices, and by their intuitive impressions of patients’ level of satisfaction, anxiety or need for particular types of information. They were not unwilling to involve patients in the treatment discourse, but therapists’ explanations about the reason for the level of patient
involvement was limited to them gaining greater understanding of what the therapist was doing and why, so that they could take on board the advice and expertise of the therapist.

One reason for patients being given the role of agreeing and complying rather than contributing on a more equal level to clinical decision-making was well articulated by Craig (T12) who suggested that the idea of contribution and decision-making was based on a notion of ownership or power within the clinical interaction:

knowledge is power and because patients have not studied for four years, they can never be equal in this area of knowledge, so they can never be truly informed

Craig – T12 – 81

He described this as a specific limitation for patients for giving their informed consent:

I suppose it comes down to the point of whether you can ever have truly informed consent by any patient in any situation. Because really we can't. Because of their lack of knowledge. You can never have you can only have truly autonomous, fully empowered decision you would need to be the surgeon or the physio. And you really can't, you're not. So...it's limited...the information, the informed part of the informed consent is always going to be limited to some extent. Just by the fact that [the patient] doesn't have the knowledge of the person sitting on the other side of the bench

Craig – T12 – 82, 84

Craig’s comments echo the scepticism previously reported in the medical literature such as the following statement by a medical doctor:

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.¹

In chapter two, I described the early reactions of the medical profession to the imposition of informed consent by the law and bioethics guidelines as one initially of denial of the need for change, or at least resistance to its demands. Therapists’ views in this research reflected similar sentiments.

Another reason accounting for why therapists did not recognise the need to include patient consent beyond agreement with their proposals for and explanation of treatment was because their construction of patient participation was grounded in what was in the patients’ best interests. Importantly, a patient’s ‘best interests’ was defined from a therapeutic perspective, and not from an ethical framework incorporating ideals of autonomy.

One of the main consequences of therapists’ views of informed consent being implicitly part of the therapeutic communication, consisting of explanations and patient agreement or lack of disagreement, is that patients’ choices and more active contribution were restricted to occasions when the treating therapist was aware of some risk associated with the treatment. In the discussion below I illustrate and discuss therapists’ understanding of patient choice within the treatment encounter and demonstrate how therapists’ perceptions of the need for patient choice were integral to their understanding and placement of informed consent as an implicit process absorbed into clinical communication.

The idea of patient choice

The idea of patient choice was perceived as largely irrelevant to the treatment encounter generally and to the obligation of informed consent more specifically. Within the structure and clinical goals of the treatment encounter, the place of patient choice was seen as irrelevant or secondary to the primary role of the therapist to make clinical decisions and to demonstrate and apply their clinical expertise.

Patient choice was framed in three related ways by therapists. First, as a source of tension within the clinical encounter. Therapists were ambivalent about the need for patients to make choices, or they found it difficult to incorporate patient choice into their clinical goals and framework of practice. Second, therapists’ spoke of specific disincentives within treatments to the idea of offering choice or, third, they described particular triggers which would raise their awareness of the need for choice. The common theme in all three conceptions of patient choice was that it was outside or marginal to the main business of physiotherapy as an idea or component of practice.

Ambivalence to choice

Seth (T16) provides a good example in his comments about therapists’ ambivalence to the notion of patient choice by initially acknowledging the need to offer alternatives so as to meet individual patient needs, then countering that acknowledgment with the practical limitations he perceived were part of such a choice:

If I feel I've got two treatment options where one would be a more manual treatment or one would be more exercise related then I would tend to discuss that option with a patient and how they feel about them because I feel a lot of people vary as to whether they want more passive
Chapter 8 – Informed consent

therapy or more hands on treatment. Ah...(laugh)...well I'd certainly inform them that I feel that exercise therapy would be of more benefit. Or I might not necessarily have offered them a manual treatment in the first place. At times. I think probably time constraints even come into it at times as well. Where, you know, if you're spending a few minutes describing sort of treatment options and pros and cons of both then that is often a few minutes that you could have perhaps achieved a little bit more with a given patient.

Seth – T16 – 27

Seth qualified this statement by suggesting that in an ideal treatment, that is free from time constraints, giving patients options would add value because it would increase their satisfaction and compliance but not because it might enhance their ability to autonomously contribute. He further qualified his statements with the proviso that the patient’s choice needs to be justified. That is, a treatment choice approved by him:

I think knowing...getting a patient's idea of what they think will help is often of very good value, yeah. Because as much as anything if they feel they are getting better the placebo effect is one thing that comes into or, or if they feel that a certain type of therapy is something that they're more likely to benefit from, or that they're more likely to do, for instance, I've mentioned exercise versus manual therapy, a lot of patients will basically say they're not good at doing exercises or that they don't tend to do it or find time, so they'll often say...you know...’put my back in’ or whatever, yeah.

I think if what they want is a justified treatment choice that I would consider, that I would use anyway... yeah. If I feel that they would benefit from something else then I would certainly inform them of that and suggest that this may help but I think that this other treatment would be more effective and I would tend to tell them that.

Seth – T16 – 41

The idea of patient choice was expressed as a source of tension for therapists because they found it difficult to reconcile giving choices to their patients with their perceived role of providing a professional service, making decisions and/or solving the patient’s problem. Aligned with this idea was the belief that if the patient had voluntarily chosen to consult the therapist, then this also implied a type of global implicit consent, and the choice for the patient was further reduced to a decision to return to the physiotherapist, or not. The idea of patients choosing the treatment or having an increased role was not considered as important or even possible in many cases. Instead the stronger theme to emerge was the concept of the role of a professional to provide expertise and advice as opposed to giving patients choices.

For example, Catriona (T10) in an extended excerpt below, articulates an awareness of options for a patient, but she also demonstrates the view that providing a professional service does not extend to providing options and that choice for the patient is necessarily limited once inside the clinic door:
I think you give them what you think they need...and so they don't have a choice then...really. I think that the choice comes in with, when they leave, whether they were happy with you. And if they are, they come back. And if they weren't it wasn't what they wanted for their back and they go somewhere else. I think they either like the way you assessed and decided what they need or they don’t. And you know, that’s not what I needed at all. I’m going to go to someone else (laugh).

I don’t think it’s really...there’s really not much value in giving them choices because there’s one way that you do best. It’s your experience and what you do. So it wouldn’t have made any sense for me to say well, here’s the way I would do it, others may do it like this and this and this. Which one do you want, because they’ve got me. There isn’t really choice because it’s what I’m best at, it’s what I think they need and it’s what I’m best at in that condition I guess.

So it does often happen which...I just don't think it's practical for one practitioner to suggest a number of options. I mean it's not like you suggesting a number of ways to mobilise a thoracic spine but, in terms of the number of overall options that you're not really going to because you've generally got an idea in your mind about this condition needs a, b, c, d. And that's what I think. So...if you gave them all of them...like...oh, we could do a to z, what do you think? People are paying for your professional expertise. And they want you to make that decision for them. They say, well I'm paying $70, what do you think I need. You're a really good practice. That's why I come here. Do you know what I mean?

Catriona – T10 – 86 – 99

**Disincentives to choice**

The second way that therapists spoke about patient choice was in terms of disincentives to offering choice. Ambivalence or tension gave way to specific disincentives when therapists viewed the treatment as successfully achieving therapeutic goals, or when they considered there was a sense of trust and familiarity between themselves and their patient. Because patient choice was subsumed within therapists’ plans and treatment agendas, it had an inverse relationship with stable and effective treatments. In other words, where treatments were achieving a good outcome and there was evidence of progress, or where the therapist was satisfied with the treatment and sensed the same satisfaction or sense of familiarity and acceptance from the patient then therapists’ views of the need for and relevance of patient choice correspondingly decreased. This was expressed by Tom (T1) below:

It seemed to be a fairly, I guess because it was a fourth treatment and because she had been improving quite well through the previous treatments I didn't feel the need to then say "are you happy with what's going on, do you think we should try something else. So that probably didn't present that opportunity to her.

Tom – T1 – 29
Similarly, where therapists perceived a clear clinical picture, and had confidence in their treatment direction as Vera (T13) suggests, or where the patient was familiar with the treatment (Ian T7), then patient choice was considered unnecessary:

> Look, I think sometimes, sometimes they fit into a clear clinical picture that you feel reasonably confident this is the way to go.

Vera – T13 – 74

Most times with the patients I see, nine times out of ten there is one treatment that is optimal. I think (informed consent) was part of the treatment. She's had mobilisation before. She'd had exactly the treatment I was giving her in the past. So in that regard I guess I didn't feel that I needed to give her any informed consent…apart from the warnings I gave her. About the sort of possible adverse effects. If I was to manipulate her…which I didn't, I don’t think I did anyway, then I probably would have given her more sort of informed consent.

Ian – T7 – 50

Two further disincentives expressed by therapists related to possible outcomes from a patient being given the opportunity to make a choice. They included the fact that the patient might make the wrong (where wrong was formulated in terms of a physical benefit) choice were they given an opportunity to choose a therapeutic plan of action, or that they may become confused by the choice.

As Leon (T6) explains in the example below, on the basis that the patient may make an inappropriate choice because of poor insight, he constrained patient choice to physiotherapy guidance to direct the choice in a particular direction:

> I think I am involved in trying to get that through to him. He sees his GP once a month and the rehab provider occasionally, so I try to think that I can help him to understand it, but I can't get…it's very difficult to get that through to him at the moment. And it's been difficult for some time. He needs more guidance than him actively choosing which direction to go. Because we hang on to him a little bit more probably. Because sometimes his choice may not be the right one.

Leon – T6 – 23

The possibility that being offered choice might be a source of confusion for the patient was related to therapists’ conception of their role as a professional and giver of services and the patients’ role as a receiver of care and health services. That is, patient choice would expose a degree of uncertainty within the treatment, that patients may find confusing, frightening and certainly not beneficial as Saul (T9) and Ray (T8) express:

> But you can't offer that or all the choices to the patient because they, look, this is controversial but, you know, if I say that one, that one and that one, they get confused or what they're after is what's the best
I just find that you can go overboard with trying to get consent, I mean, for any sort of treatment that you do. I mean, the fact that the person has come here implies that they are seeking treatment and um...I find with informed consent particularly with regards to manipulation. You just have to be very careful. It's the sort of thing that is likely to scare a patient much more so than reassure a patient.

Ray – T8 – 39

**Triggers for offering patients choice**

There were three main triggers that altered therapists’ ideas or perceptions of patient choice and led to a change in the amount of information they gave or altered the opportunity for patients’ contribution to the interaction.

The first was a patient-initiated trigger and the second two were dependent upon recognition by the therapist:

1. **Patient-led trigger - assertiveness**

   If the patient indicated some dissatisfaction with the treatment or diagnosis, or was assertive in their requirement for information or a particular type of treatment, the therapist would always change the amount and type of information. This trigger relates to the discussion of therapist responsiveness in the previous chapter. Although therapists formed views about the nature of the problem they were dealing with, including the type of patient and the patient’s individual needs, they were also open to patients’ contributions and any stated or unstated requirements. In other words, a patient-led request triggered a reactive response in the therapist.

   However, a reactive response is different from the therapist being pro-active about providing opportunities for patients’ autonomous contribution to the interaction. A reactive response to the need for extra information or alternatives, whilst demonstrating responsiveness, also suggests that regard for patient choice and contribution is not a usual part of the exchange. It is not built into the normal framework of clinical interaction.

   There were many examples of therapists adjusting their explanations according to their interpretation of patients’ stated requirements. In the following excerpt, Linda (T15) describes how the information she gave to her patient, a forty-five year old man with low back pain, was triggered by his straightforward request:

   Sometimes it is quite easy because even with this fellow it is quite easy because he came in and he wanted a couple of things. He wanted an explanation as to why he had a flare up
Most therapists tended to wait for the patient to indicate a particular concern, rather than pro-actively give options or choices, especially if the patient had not indicated a need for anything different. In the excerpt below, Ray (T8) states how he relied on patients to let him know:

> Often people will state if they’re not happy about some technique or procedure… and often they’ll state quite clearly from the start that I don’t want any cracking, and that you don’t do any cracking or that they’ve had a bad experience and that makes it quite clear. It doesn’t mean it won’t form part of your treatment, it just means you’ve got to make sure they understand and they know…but most people will make it clear and if you put them in a position where they feel that something forceful is going to happen they will speak up.

Ray – T8 – 46

2. **Therapist-led trigger – uncertainty**

If the therapist felt the treatment was not achieving an appropriate therapeutic outcome, if they were uncertain about the condition, or if the treatment required extra effort from the patient they would offer more information and choice, or seek the patient’s more explicit agreement. The following comment from Craig (T12) illustrates how poor or slow progress might trigger an enquiry from the therapist to the patient:

> So the key times are early on and if things aren’t changing and I’ve seen the patient twice and listed nothing’s changed and then I’ll say well what do you think about it.

Craig – T12 – 45

In the next two examples, Catriona (T10) discusses the significance of an uncertain outcome and Seth mentions a treatment which is potentially uncomfortable for a patient. Both conditions alter the amount of information and options they consider giving to a patient:

> I give people options when I am not that confident, perhaps more than I do when I am confident in treating somebody with an ankle sprain that is just dead easy or a calf strain and you know that they are going to get better doing those options and it is so obvious that they are the only thing to do so I don’t give them options, but with this guy with the knee, there was a couple of ways you can go and so with those people where their actual treatment program is not a guarantee they will get a good outcome, I suppose I give the realistic expectation that it is a process and we will try these or you can try this and you may or may not end up at the same point after you have tried those options and if I think their condition is quite irritable and I’m not quite sure what is going on and I think the treatment might make them worse I am very aware of giving them more information.

The only time I need to get consent or agreement with patients is if they come in and I think the main thing they need is an exercise program and I have to really explain to them that that is what really is going to help them and they really have to apply themselves to do that for the 6
or 10 weeks or whatever and do not expect any improvement unless they do that. I guess that is tied up in compliance though.

Catriona – T10 – 32

[I think patients need more explicit choices] when particularly if the techniques used are more confronting for the patient. I would tend to give further description or definitely ensure that they are aware of what is planned. Although obviously they should be aware at all times but I think in areas such as dealing with parts of the body that are more exposed or that sort of thing. I tend to be a little more explicit with describing what’s going to be happening.

Seth – T16 – 22

3. Therapist-led trigger - risk

If the therapist recognised a risk associated with the treatment, they would give more information about the proposed treatment. That is, the way that therapists gave information would become more purposeful and separate from the usual explanation about the treatment. Whilst they focused more carefully on their explanation, they did not give more options or alternatives about the treatment or pay more attention to the patient’s contribution.

In the first example below, Jean (T4) made a point of asking the patient whether she was happy for her back to be re-taped. (During the interview Jean had explained that she regarded the use of tape to have associated risks of skin irritation.) Although in chapter seven I discussed Jean’s treatment as providing a good example of a ‘discourse of responsiveness’, this was the only question during this treatment encounter which was directed explicitly towards seeking patient permission:

Now, would you like me to tape it again?

Look, I’ll do anything that you think would be a good idea.

Jean – T4 – 247

The next example involves the application of ultrasound by Rebecca (T5). Ultrasound is an electrotherapy modality which carries risks of burning the patient, if the patient does not give feedback about the temperature, and in that sense is a more invasive modality:

Ok. Lie on your stomach for me (long pause) What I’m going to do is a thing called an ultrasound. Have you ever heard of or used an ultrasound?

Yeah I have.

What was that for?

Umm, I think I had one on my lower back.
Right – so I’ll reiterate – it uses high frequency soundwaves that vibrate the tissues causing increased movement. So if you’ve got very stiff, sore area of tissue, it will help. So, is it all right if I use that on there?

Rebecca – T5 – 56

The presumption of patient agreement in the above exchange was based on the fact that the patient had previously received ultrasound. The specific request for permission was made at the end of Rebecca’s explanation, where she asked, ‘so is it all right if I use that on there?’ Rebecca’s response to the provision of a treatment carrying an associated risk was to increase her explanation, rather than give extra opportunities for contribution and choice by the patient.

Choice was collapsed into permission to proceed, which was consistent with Rebecca’s explanation of informed consent in the interview. During the interview Rebecca explained the process of obtaining informed consent and offering patient choices as part of the usual explanations about the treatment in the following way:

No I don’t ask “can I have your consent to…” but I will explain to the patient what I want to do and why I want to do it and ask them is it ok if I proceed with that

Rebecca – T5 – 10

Giving the patient the option to say ‘yes I will proceed’ or ‘no I would prefer not to proceed’ was triggered by Rebecca’s knowledge of potential risks of ultrasound. It was not triggered by the idea that the patient has an autonomous right to make a choice or by an enquiry as to the patient’s own preferences.

In the next example, Ray (T8) is discussing manipulation of the cervical spine as a ‘forceful technique’. Here he suggests that what is important is that the patient is told about what he plans to do:

If I was going to do anything forceful, I mean I would just ask them. You know, are you happy with this and I just tell them I’m going to suddenly do something.

Ray – T8 – 48
This type of reasoning is not dissimilar to the explanation expressed in the 1767 legal case I mentioned in chapter two where information was given to the patient in 'order that they may take courage.'

Although the triggers outlined above led to a change in the amount and type of information given by the therapist to the patient, the alteration did not extend to giving the patient information and then allowing the patient freedom to choose. Extra information or different information was framed from a therapist determined therapeutic perspective and the patient was expected to agree.

The idea of autonomous patient choice based on the significance of respect for autonomy and not necessarily linked to treatment outcomes defined by the therapist was not seen as relevant in therapists’ definitions of implicit informed consent. If the therapeutic goals of treatment were to be achieved, then the idea of patients choosing other than the successful therapeutic course of action was counter-intuitive to the therapist, given their conception of their role as a professional.

Therapists’ views about patient choice and the need for informed consent and the reasons for offering different choices are neatly summarised by Adam (T11) below:

> When I explain to the patient what’s wrong, I’ll explain what we are going to do and why so they understand what we are doing, especially if it’s going to be painful...I suppose then I wouldn’t then often say to a patient do you want to try this one, do you want to try that one, do you want to try this one, so I’ll sort of suggest this is the way we’d normally go about it unless it’s an issue.

Adam – T11 – 22

In this quote, Adam encapsulates the discussion in this chapter. That is, that the process of informed consent is mostly about providing explanations, rather than offering choices. The only time choice is an ‘issue’ is if the patient specifically asks for choice or the therapist recognises some uncertainty and risk associated with the treatment. The information made available to the patient was inevitably information deemed relevant by the physiotherapist.

**Summary of the idea of choice and informed consent**

In summary, in defining the informed consent process, therapists emphasised their responsibilities to offer information and to ensure that patients understood their treatment.

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2 See the reference to *Slater v Baker*, note 20 in chapter two.
plans and agenda. They believed they had fulfilled their obligations of obtaining informed consent and provided sufficient choices if they had:

1. assessed (according to their judgement) patients’ capacity for understanding the information and decision making competencies;
2. provided information and explanations about the proposed treatment; and
3. obtained mostly implicit and sometimes explicit agreement from the patient to the proposed treatment.

Therapists’ views about the meaning of informed consent were narrowly construed or absorbed into routine goals of communicating information to patients, rather than understood as an opportunity to facilitate patient involvement. There was a belief by therapists that patients expected them to make decisions, or would most likely be confused by too many choices. The most common way that therapists defined informed consent was as an explanatory process. How much explanation, the content and the timing of the explanation was a decision that was mostly made by the treating therapist, on the basis of their assessment of their patients’ needs.

**Informed consent in practice and informed consent in theory**

In chapter two, I developed a gold standard or what I have termed throughout this thesis as an ‘ethically enriched’ process of informed consent. The broad features of this preferred process are its direct and logical link to the underlying ethical theory of autonomy and its promotion of a particular attitude of reflection about the meaning and capacity for autonomous action in another person. In chapter three I specifically endorsed Katz’s definition of psychological autonomy which refers to ‘the capacity of persons to reflect, choose and act with an awareness of the internal and external influences and reasons they wish to accept.’ By internal factors, I am referring to the particular values and beliefs held by the patient, including their capacity to reflect on any difference between their values and those of the physiotherapist and the underlying values and assumptions informing the physiotherapists’ treatment choices. By external factors, I am referring to the constructs of therapeutic care in the private practice setting, such as a twenty to thirty minute time limit,

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3 Katz, J. (2002), p 111. This definition is in chapter three, p. 88.
the biomedical priorities of treatments and a focus on techniques and advice that promote and expect compliance and cooperation.

All of the elements of informed consent would alter if they specifically incorporated ideas inherent in the ethical meaning of autonomy. The content of the information given to a patient according to this ‘ethically enriched’ model would at a minimum contain details of the risks, benefits and alternatives of any proposed treatment, required by law and professional guidelines. However, more importantly, the underlying purpose of and motivation for the giving of information would differ, and this would automatically expand the content of the information, and the consequences for the informed consent process.

According to the ‘ethically enriched’ model, information is given on the basis that patients have both a right to a version of the technical knowledge informing physiotherapy practice and, more importantly, an equal ability to reason and hold values and beliefs about their health and their participation in the clinical encounter. The motivation to give information derives from respect for a patient as an equal person rather than from the effect that the information might have on the therapeutic outcome.

The picture that I have constructed about informed consent in practice, in this chapter, and clinical communication in general, in the two preceding chapters, is different from the ‘ethically enriched’ process on several levels. First, therapists gave information to patients on the basis of its potential effect on the therapeutic outcome. That is, the focus or central theme of therapists’ clinical communication was on benefiting the patient, or a concern for their patient’s best ‘therapeutic’ interests. The motivation for the framing of information, the content of the information and any opportunity for patient contribution was its effect on the therapeutic outcome. This basis and underlying motivation was evident in the overall structure of the clinical communication, discussed in chapter six, including the types of messages conveyed through therapists’ explanations and questions. It was evident in therapists’ interpretation of the ideals and principles of practice and in the way they intuitively responded to patients and at the same time demonstrated their expertise.

Therapists’ motivation for giving patients information was thus influenced more by its instrumental value on aspects of the therapeutic outcome, such as enhancing patient compliance, satisfaction and trust of the patient in the therapist. Whilst I acknowledge that these instrumental reasons are important and both ethically and clinically valid, they do not incorporate the deeper meaning of autonomy and therefore they respect only part of a
patient’s capacities for autonomous action, namely, that part that accords with the goals and interests of the treating physiotherapist.

I argue on the basis of this research that therapists’ motivation and interpretation of the need to give patients information did not derive from the meaning of the underlying ethical theory of autonomy and as a consequence did not recognise the ‘external’ and ‘internal’ factors which might enhance or detract from a patient’s ability to give their informed consent to treatment. The boundary of patients’ autonomous contribution was set at the door of the clinic, that is, whilst they may have made an autonomous decision to attend the physiotherapy clinic, their level of contribution and choice became much more narrow and restricted once inside and interacting with the therapist. Through their clinical communication, therapists did not demonstrate an understanding of the factors that might impact on patients’ autonomous capacities. That is, therapists did not explicitly acknowledge (in the interview) or explicitly attend to (in the treatment encounter) internal factors such as individual patient values, beliefs, emotions, psychological capacities or external factors such as the effect of the clinical aims and structure inherent within physiotherapy treatment.

The predominant ethical value underpinning therapists’ practices was one of beneficence. Respect for a patient’s autonomy was interpreted as respect for their freedom to participate in the clinical interaction. Moreover, patient participation involved conforming to the nature and structure of the clinical interaction as determined by the therapist. In the concluding chapter of this thesis, I extend this discussion of difference between the ethical theory of autonomy underpinning the process of informed consent and the actual implementation of the process in clinical practice. Importantly I outline the key implications of the differences and present recommendations for responding to such difference.
**CHAPTER 9: Physiotherapy practice: The rise of patient autonomy**

**Introduction**

In this final chapter, I step back from the analysis and draw out the key findings from both the empirical examination of the therapist/patient interaction, and the review and analysis of ethical theory and professional practice discourse in the earlier chapters.

This concluding chapter has three aims. First, to discuss the implications of the research and its ability to contribute to the wider body of knowledge about physiotherapy clinical practice. This will include suggested directions for future related research. Second, to outline the key conclusions which I have made on the basis of the research. Third, on the basis of the conclusions, to make recommendations for clinical practice.

A strong and consistent message that I have given in forming conclusions and making recommendations for practice is the fundamental importance of critical reflection in clinical practice. That is, reflection about the content and basis of ethical knowledge including the way it is understood and applied in practice and its possible effects on the patient. This same message of critical reflection needs to be applied to the nature of the knowledge generated by the research as a whole, its scope, limitations and therefore its contribution to the specific body of physiotherapy ethics knowledge and more generally to health practitioner ethics knowledge.

This research is qualitative, relying broadly on constructivist and interpretivist ways of building knowledge. Arguably a narrow lens was used to examine, interpret and construct knowledge of physiotherapy practice. Narrow in the sense that it was focussed on searching for evidence of a particular type of (‘ethically enriched’) process of informed consent within therapists’ communicative practices. The research also examined the clinical communicative practices of only seventeen physiotherapists, and their patients were not included as research participants. The theoretical schema of the nature and consequences of therapists’ clinical communication developed from my analysis, is generalisable outside of the research context only insofar as the scheme or theory is pertinent to the experiences of other practitioners. However, the boundaries imposed by the qualitative nature of the
research process, the specificity of the focus and the number and type of participants, I would argue, as have others previously,¹ is also a strength.

For example, Morse and Field describe three important functions of theory developed from qualitative research within a practice discipline.² First, that the theory provides insights into practice, rather than just a description of practice. These authors suggest it is these insights which may be used to revise or alter clinical practice in other settings. Second, due to the nature of qualitative findings as a rich and contextual description of clinical reality, they provide opportunities for readers to ‘make sense of otherwise incomprehensible situations and behaviours.’³ Third, the theoretical explanations developed from qualitative examination may be used as a conceptual framework to guide further quantitative or qualitative research.

The conceptual picture developed from this research, including the consequences of therapists’ clinical communication, serves similar functions to the first two described by Morse and Field. In the discussion below, I provide an overview of the key insights developed from my examination of practice and the way these insights may be used to alter practices and understanding of practices.

As a catalyst for future research, the boundaries and defined context of this research provide both a focussed and contextual examination of the clinical interaction and, as a consequence, point clearly to future areas of research to complement and build on these findings. For example, my analysis of patients’ contribution within the clinical interaction was based on both their responses within the interaction and a comparison in theory of the effects of physiotherapists’ communication with those of an ‘ethically enriched’ process of communication. There is a clear need for the actual impact of therapists’ communicative strategies to be examined from the patients’ perspective. An examination of how individual patients view, interpret and desire autonomous contribution in the form of informed consent would clearly add to the interpretation of their requirements from the perspective of this research.

Whilst the influence of physiotherapy education and principles of practice were recognisable in the content and focus of the communication between patients and therapists, I did not set

out to examine physiotherapy ethics curricula. However, in as much as it is reflected in actual practice, there is a need for further research that examines both the content and process of teaching ethical principles, their integration with the rest of the curriculum and the impact of ethics teaching on clinical practice.

Conclusions from the research

My overall conclusion from this research relates to the relationship between ethical theory and clinical practice. My examination of ethical theories of autonomy using the iceberg framework as a model of enquiry, demonstrates that they provide a profound basis for and a detailed account and exploration of the autonomous capacities and rights of the patient as the recipient of physiotherapy treatment. Using the ethical meaning of autonomy to guide clinical practice means that a therapist needs to be aware of not only their patient’s freedom to make a choice, but also their capacity to do so. Moreover, a patient’s capacities and opportunities to act autonomously depend not just on removal of obvious external constraints, or compliance with established elements of informed consent, but also on recognition of more subtle barriers such as the goals, structure and strategies of the clinical interaction itself. Based on this review of ethical theory, my contention and conclusion is that a practitioner educated in and conversant with the ethical theories of autonomy has a framework and an armoury within which he or she can flexibly adapt to patients’ differing capacities and abilities to autonomously contribute to the clinical communicative dialogue.

Based on my examination of therapists’ understanding of and ways of implementing informed consent within clinical communication, I make specific conclusions about the underlying goals and values of clinical communication and the actual strategies used. A significant conclusion about the nature of clinical communication in the private practice settings examined in this research is that the most visible ethical framework underpinning therapists’ communication with their patients, including the way they obtained patients’ informed consent to treatment, was one of beneficence. That is, therapists valued and defined their role as the provider of treatment, and the person responsible for solving patients’ problems, or instructing the patient as to how to manage their problem. They valued patient trust on the basis that it enhanced their ability to effectively treat their patient and they valued patients who complied with and contributed to the overriding therapeutic
goals of the clinical encounter. My contention is that all of these values lead to an overriding one of the primacy of beneficence.

Aligned with the underlying value of beneficence, the dominant feature of the informed consent process identified in therapists’ communication was that of information disclosure, where the therapist gave patients information and explanation as to the nature of the treatment and the way they were making clinical decisions. That is, therapists communicated information to increase compliance and to facilitate the best outcome.

With reference to the iceberg framework, I conclude that therapists’ understanding and implementation of the informed consent process was confined to above surface elements of the this model. It did not include an explicit understanding or incorporation of the underlying ethical theory of autonomy. It was informed and shaped by influences, such as professional codes of practice and legal obligations, but these influences were relatively shallow and restricted to specific situations where therapists were aware of risks of treatment. The ideal of ‘ethically enriched’ informed consent, which I developed on the basis of a multilayered definition of informed consent, was not evident. In defining informed consent as an ordinary or routine part of their interaction, therapists re-modelled informed consent underpinned by autonomy to be informed consent grounded in beneficence.

That is not to say that therapists were not aware of or had not formed views about aspects of their patients’ autonomy, such as their capacities for reasoning and weighing up treatment alternatives and contributing in other autonomous ways. Therapists were willing to engage with their patient and they actively characterised and interpreted their patients’ needs and personalities. However such knowledge and perceptions did not overtly inform or influence the communication within the interaction. Therapists were aware of the possibilities of different values, beliefs, motivations and interests within their patients, and they attended to subtle requirements of patients’ needs and reactions, but this was done at an intuitive level. Proactive or explicit seeking of information about patients’ capacities and desires for contribution to the clinical communication were not evident.

Importantly, the overall structure, content and strategies of communication had the effect of limiting patients’ autonomous contribution. I suggest there are three possible explanations for this mismatch in therapists’ awareness and actual practices. The first is that therapists did not see the relevance of giving patients such opportunities to the therapeutic goals of the clinical encounters. Second, and related to the first, they did not recognise that such opportunities for patients’ autonomous contribution were present because of a narrow
conception and understanding of the meaning of autonomy. Third, they were aware of their patients’ autonomy, but their clinical framework of interaction, including the clinical language, structure and style of communicating did not enable implementation of such understanding and awareness. These explanations are not mutually exclusive. They may all contribute to some extent and collectively provide a plausible explanation for therapists’ ways of communicating in the clinical encounter.

Based on the discussion in the three findings chapters, all of these explanations are relevant. The structure of the clinical communication and the emphasis on solving patients’ physical problems was a dominant framework that effectively excluded other ways of relating to patients. Gaps in that dominant structure were not recognised for the opportunity they might have provided for promoting patients’ more active and autonomous engagement in the clinical encounter. Moreover therapists’ obvious awareness of broader aspects of their patients’ requirements did not translate into broader and more flexible ways of communicating with them.

**How much does an ‘ethically enriched’ informed consent process matter?**

One question which might be posed at this point, is whether or not it matters if physiotherapists in private practice clinical settings do not obtain the informed consent of their patients, other than in an implicit way. Related to this, whether or not it matters if therapists’ overall goals and strategies of communication are steeped in values of beneficence and in acting in the patients’ best-therapeutic interests rather than giving more prominence to the ideals of patient autonomy.

There are three possible arguments to support the proposition that such considerations are of no moment. First, it might be argued that physiotherapy treatment is relatively risk free, especially when compared to surgery or other invasive medical treatments. Support for this argument would be found if risk of injury associated with treatment was regarded as the determinative factor in shaping obligations of informed consent. Arguably the physiotherapy guidelines about informed consent written for cervical manipulation have adopted this premise.

A second argument might be made on the basis of patients continuing attendance at physiotherapy and their expressed need for and compliance with physiotherapeutic expertise. In other words, patients themselves seem to be content with the processes of
communication as they presently exist. This argument derives support from within this research, where therapists demonstrated some resistance or at least ambivalence to the idea of patient choice.

The third argument is that the nature of physiotherapy treatment and the whole ethos guiding practice, is to bring about a benefit in either physical function or ability to manage a physical problem. The underlying premise here is that as a fundamental ethos guiding physiotherapy practice, the process of informed consent should be subsumed within it. In this research, therapists articulated and demonstrated within their communication an ethical framework of beneficence. Their explanation of where informed consent is positioned in physiotherapy practice was grounded in their goals and principles of practice. In other words, their understanding of the informed consent process was restricted by the dominance of a set of values which favours beneficent outcomes over promotion of patient autonomy.

In responding to all three arguments, I return to the initial justification for and context of the research, discussed in chapter one. Physiotherapists are a recognised health profession with an associated specialised body of knowledge, including an underlying framework of ethical principles guiding their practice. In the 2020 vision statement of the Australian Physiotherapy Association the aims and vision for future physiotherapy encompasses the following ideals:

Physiotherapists are patient-focused practitioners and the focus on active involvement of patients will increase. Physiotherapists will spend more quality time during consultations working with patients to ensure that they understand the benefits, risks, and alternatives to the proposed treatment. 4

By this statement, the profession not only envisions for itself a level of professional maturity and autonomy underpinned by ongoing research into its effectiveness, but it also envisions a future where the involvement of the patient will be active rather than passive. My contention is that an understanding and implementation of the ideals of patient autonomy are integral components of such a future.

If the profession is striving to be recognised for its independence and trustworthiness, I contend that its commitment to acknowledging and understanding the effect of ethical theory underpinning its clinical practice is equal in significance, if not more so, than a

commitment to knowledge of, for example neuro-physiological theory and clinically based evidence and principles driving clinical practice. The basis of this contention relates to the nature of professionalism, and in particular the nature of professional healthcare, which requires more than what Fullinwider terms as ‘elementary obedience’ and ‘self interest’ towards rules that guide practice.\(^5\) My analysis of autonomy as an ethical theory and its relationship to informed consent as a clinical process is that health professionals in general, and physiotherapists as a specific example, have an ethical obligation to engage in moral deliberation beyond adherence to the dictates of their code of ethics. As John Ladd has argued, the imposition of principles or codes of ethics on other people ‘in the guise of ethics contradicts the notion of ethics itself, which presumes that persons are autonomous moral agents.’\(^6\) Ladd’s comments are especially pertinent in the context of providing professional care, where the expectation of a health professional encompasses particular ethical and clinical standards of expertise derived from within the profession.

In the case of informed consent, therapists need to understand not just how to implement the established elements of informed consent but, taking the meaning of autonomy as it applies to professional practice, they should be able to articulate and understand reasons and values underpinning its implementation.

Finally, whilst recognising that physiotherapy has always been a practically oriented and task focussed profession, whose main mode of effecting a therapeutic benefit is to change physical structures by stretching, massage, strengthening and co-ordinating, and motivating patients to be ‘the best they can be,’\(^7\) there is also a need to heed externally based calls for changes to patient/therapist relationships. Those calls include the need to recognise patients’ rights and expertise within the clinical interaction and require a recognition of different levels of autonomous contribution. They demand, in other words, an ongoing and active review of physiotherapy values, underlying ethical theory and principles guiding practice. The need for active patient involvement is recognised in the profession’s vision statement and delivering the vision requires a re-thinking and re-ordering of the clinical encounter.


The need for deeper knowledge about ethical theory underpinning clinical practice leads to my final conclusion, which is to suggest what is needed to link theoretical knowledge about ethics to practical implementation in the form of fulfilling practical ethical obligations. Based on my review of theory and examination of practice, I conclude that there is a need for reflexive and critical scrutiny on the part of physiotherapists of their own professional values, beliefs and professional clinical practices.

I contend that in order to make use of philosophically based ethical knowledge, therapists not only need to be conversant with a deeper and more theoretical level of ethical knowledge, they also have to be prepared to be reflexive about its application. Here I borrow from the meaning of reflexivity as it is referred to in the research process. In that process, reflexivity refers to a type of scrutiny and awareness of not only the research practices, but also the sort of factors that influence the researcher’s construction of knowledge, such as their individual interpretations and ways of presenting findings. Rice and Ezzy describe reflexive research as a process of acknowledging ‘that the researcher is part and parcel of the setting, context and culture they are trying to understand and analyse.’ They are suggesting, in other words, that the researcher is the instrument of the research. I suggest that this same type of reflexivity is necessary for physiotherapists in their ways of communicating with their patients. The ethical values, the principles and goals of practice and the methods of communication all impact on a patients’ actual ability to contribute autonomously in the clinical interaction. Therefore, in order to put into practice the ideals of an ‘ethically enriched’ informed consent process, there is a need for knowledge of the detail and factors that make up the theory of autonomy as well as a knowledge of how therapists’ own practices, clinical frameworks and ways of reasoning impact on a patient’s autonomy. This reflexive and critical scrutiny of themselves and their ways of practising clinically and ethically is a vital component of implementing ethical theories.

**Recommendations**

My conclusions lead to three specific recommendations.

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1. **There is a need to enrich physiotherapy clinical practice with ethical theory**: The theoretical or philosophical meaning of the ethical obligation to respect patient autonomy should be used to guide its implementation in clinical practice.

2. **There is a need to re-examine physiotherapy practice goals**: The goals of physiotherapy treatment and the underlying values of beneficence, assumptions about the therapeutic relationship and principles of practice, should be exposed, examined and re-framed in light of the ethical meaning of autonomy.

3. **There is a need to reframe and re-constitute current physiotherapy communication skills**: Physiotherapists’ skills in responding to their patients’ individual needs should be expanded and re-directed towards a more pro-active curiosity about their patients’ understandings, values, beliefs and desires to contribute to the treatment encounter.

**Recommendation 1: Enriching Practice with Theory**

What this research has demonstrated is that a theoretical account of individual autonomy, which is coherent and defensible, is important as a groundwork for the particular applications, conditions and values that link it with informed consent. My first recommendation to advance the depth of knowledge of ethical concepts of autonomy to inform and underpin clinical communicative practices is based on my review of the foundation ethical theories of Kant and Mill and their interpretation by Dworkin and Young. In particular, that flexibility is afforded when one has a deep knowledge and understanding of concepts and theories such that the ethical theories of autonomy provide a structured framework from which a physiotherapist educated in them can proceed. Gaining a patient’s informed consent to a treatment based on this understanding of what autonomy means must therefore encompass at least some curiosity and at best a reasonable enquiry as to the internal motivation, capacities for reflection, desires and beliefs of the patient.

As I discussed in chapter three, the value of Katz’s conversation model in the clinical setting was not because it enunciated a set of duties for health practitioners to follow, but because it fostered reflection about the meaning of autonomy and autonomous action. It did not seek to reduce clinical decision-making into either the job of the patient or the health practitioner. Using the theoretical knowledge and understanding of autonomy as outlined by Katz meant that the strategies of communication would not be specified in the form of which
information should be given and which questions should be asked in order to discharge the legal and ethical obligation to obtain informed consent. The communicative strategies would emerge from an understanding of the meaning of autonomy, and its value in the clinical encounter.

The focus of current physiotherapy practice is upon evidence-based practice and objective justification for that which is done by way of treatment. Links between theory and practice are well recognised as the basis of professional practice. In the various clinical research areas currently being pursued, physiotherapists have not waited to be told by the law or by consumers of health care to research, for example, the association between abdominal muscle strength and low back pain. Instead individual physiotherapists have recognised the possibility of that link through their deep (internal) knowledge of relevant neurophysiology and anatomy and as a result of overriding (external) societal and professional expectations to find evidence for current practice.

Whilst physiotherapists in Australia and elsewhere have recognised the need, in broad terms, of the importance of ethical values and obligations guiding practice, I contend, based on both my review of the physiotherapy ethics literature and empirical examination of clinical practice, that the recognition is broad and rhetorical rather than detailed and contextual. The need to actively find links between ethical theories and guidelines and the realities of clinical practice is less usual in physiotherapy ethics literature. Some authors have attempted to draw ethical theory and practice closer together by examining physiotherapists’ perspectives about ethical issues. However there have been very few physiotherapy writers who have examined the underlying ethical theory for its meaning and as a way to frame its practical implementation.

It is also well established that in applying clinical skills, physiotherapists who are regarded as expert practitioners have a depth of knowledge and experience upon which they rely for a range of clinical tasks. The strength and usefulness of a practitioner’s knowledge is often related to the depth and flexibility of that knowledge such that it may be applied and adapted

11 See the following studies from chapter three in the context of the hypothetical case scenario, Hodges, P. (2000); Hungerford, B., Gillear, W., & Hodges, P. (2003).
to different patient conditions and their presenting symptoms.\textsuperscript{13} This research demonstrated that ethical theories of autonomy require the same depth of knowledge, recognition and acknowledgement in the clinical encounter as other established bodies of knowledge which the practitioner brings to the encounter.

Importantly, the main message inherent in the philosophical knowledge base of why autonomy is important and what it consists of, discussed in chapter two, is not so much a prescription of what information to impart or what obligatory action to take, but, rather, a call to think about the meaning of autonomy and what sort of attitude to adopt. This philosophical knowledge base, in turn, provides a more flexible guide to ethical reasoning in a range of circumstances involving informed consent.

**Recommendation 2: Re-examining Goals**

My second recommendation is to both expose and then re-examine the goals of physiotherapy practice in light of the ethical meaning of autonomy. This recommendation arises directly from my empirical examination of physiotherapy practice. My examination of therapists’ communication practices was from the perspective of the goals and meaning visible from the content, structure and strategies used, and from the consequences that such communication had for the ideals of respecting, promoting or missing opportunities to promote patients’ autonomous contributions within the encounter.

The goals of therapists’ communication were focussed on therapeutic outcomes, clinically oriented, and reflected values of beneficent care. There was a clear difference between those goals and the goals and features of communication derived from a goal of promoting a patient’s autonomy. Although providing beneficent treatment and respecting a patient’s autonomy are not mutually exclusive activities or goals, I suggest that the interpretation of autonomy, demonstrated through therapists’ communication with their patients in this research, highlights an emphasis on the former over the latter as a basis of the interaction.

This research has shown that therapists are already motivated in their communicative interaction with their patient by its effect on the therapeutic outcome. In justifying the second recommendation, it is tempting to build on this motivation as a basis for redirecting

Chapter 9 – The rise of patient autonomy

the focus and goals of clinical communication. I recognise that there is a substantial body of literature that suggests communication that more actively focuses on respecting a patients’ autonomy can lead to better health outcomes\(^\text{14}\) and treatment effectiveness\(^\text{15}\) due to its effect on patient empowerment, greater control\(^\text{16}\) over their illness and enhanced compliance.\(^\text{17}\) I also recognise that goals of improved patient contribution and compliance are particularly relevant for physiotherapy practice. However, ethical obligations, values and weighing up of principles are already shaped according to their effect on this predominant goal of beneficence and patient satisfaction. Any further argument that suggests changes to communication based on its effect on patient satisfaction or some other beneficial outcome without addressing the underlying moral value of the change would result in a ‘more of the same’ approach. Therefore, the re-examination of the goals of the physiotherapy encounter needs to be done in the spirit of a broad understanding of professional practice and with the acknowledgement that autonomous professional practice requires self reflection about reasons, desires, capacities and goals of practice. A sound and detailed knowledge of ethical theory is required to inform the clinical encounter and to enable the provision of services to move to the next level, a level reasonably anticipated of a primary health care practitioner.

**Recommendation 3: Re-framing Skills**

In making my third recommendation, I build on the strengths and knowledge already present in clinical communicative practice and suggest a reframing of physiotherapists’ clinical communication strategies. This research demonstrates that what is required to integrate ethical theory into clinical practice is an ability to see the importance and possibilities for


moral agency within current practice. The research has affirmed other studies that have demonstrated therapists’ skills of sensitivity to patients’ individual capacities and needs,\(^\text{18}\) and their ability to perceive and describe emotional, psychological and environmental factors that may impact on an individual patient.\(^\text{19}\) I found evidence of this awareness in this research, both in therapists’ responsiveness to patients’ needs and in their characterisations of their patients in the follow up interviews. However I also found that those same skills were constrained by the overall focus of the therapeutic encounter, to achieve a therapeutic outcome. Physiotherapists clearly have a capacity to be insightful within the interaction with their patients. The principles of physiotherapy practice value a holistic and functional approach to patients and their disabilities. However, I contend that without the knowledge of how to reconstitute or re-frame their insight using a deep and detailed knowledge of patient autonomy, that insight may be channelled in directions favoured by the prevailing force, such as achieving a measurable, evidence-based outcome. Specifically related to obtaining informed consent, there is likely to be, and was in this research a tendency to conform to narrow formal requirements of information disclosure, rather than honouring or giving effect to the ethical ideals and meaning of respecting a person’s autonomy.

Katz provides some positive guidance of the types of skills needed to recognise the nuances of a therapeutic interaction, including the particular needs of individual patients. He refers to the importance of psychological theory and skills of psychoanalysis to facilitate an understanding and respect for the internal motivations (and autonomy) of others. In particular, Katz suggests that health professionals should be aware of the possibility that their patients and themselves may be motivated to accept or to offer choices based on both conscious and unconscious (including deeply held emotional) forces,\(^\text{20}\) or on the basis of rational and irrational thoughts and impulses.\(^\text{21}\)

My approach is different from that. I suggest that therapists already have a framework of practice and an interest in connecting with broader aspects of their patients. This was demonstrated in this research by their willingness to respond to their patients’ individual requests and personal situations. However, I suggest their underlying ethical framework of


practice needs to be more actively questioned and understood in broader terms. Physiotherapists need to re-evaluate their well established goals of providing therapeutic benefits for the patient and they need to examine the relatively neglected notion of patient autonomy as a basis of practice in general, and specifically in relation to informed consent. If the ethical meaning of patient autonomy was elevated as a basic value underlying therapeutic interactions, then therapists’ skills of responsiveness would be channelled automatically in favour of the features of an ‘ethically enriched’ process of informed consent. As Purtilo suggests, the goals of patient care, from an ethical perspective, should be interpreted as paying ‘attention to what matters to the person’ and what the health professional’s role has to offer in that regard. At a simple level, therapists would need to be genuinely curious about their patient, rather than be constrained by a narrow clinical reasoning framework, such that their curiosity would be an expanded one incorporating the underlying ethical theory of autonomy. In summary, the types of skills needed by a therapist to implement an ‘ethically enriched’ informed consent process are a combination of theoretical knowledge and critical reflection about that theory as it relates to practice.

The final recommendation to emerge from this research concerns suggestions for further research topics. For example, this research has focused on therapists’ communication. There is a clear need for a study that looks at patients’ perspectives. Another study, which would build on the knowledge developed in this research is one that uses videotapes of the clinical interaction, or direct observation by a researcher in the treatment room to take account of the non-verbal components of the interaction. Whilst this study did not control for physiotherapist variables such as expertise, experience, age or gender, a study that focused on one of these variables as a more detailed examination of the therapist/patient interaction would similarly build on this research. Finally a series of comparative studies of clinical interactions, such as across countries or between allied health professions and medical professions would add to the body of knowledge about communication in the clinical encounter.

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Final comments

Overall, the recommendations stemming from this research about how therapists should go about obtaining informed consent are based on a knowledge and understanding of theory, a knowledge and understanding of their own practices and a knowledge and understanding of how each informs the other. The recommendations go further than adding obligations on to otherwise unexamined clinical practices as a means of reacting to requirements imposed externally. They require physiotherapists to look inwardly at their own values and ways of practicing rather than to monitor and respond to outside pressures. The specific strategies required to implement these changes to practice and practice knowledge are not the focus of this research. However, they necessarily relate to education about clinical practice, ethical knowledge and ethical practice.

This research has provided an overview of both the ethical theory underlying the externally based calls for change to the process and significance of informed consent, and a glimpse of the realities and focus of the clinical encounter within which such theory must exist. Based on this overall view of theory and practice, my recommendations for change go beyond how to best meet externally imposed challenges. My recommendations, based on a motivation to increase the coherence between ethical theories of autonomy and actual clinical practice require inward or below the surface reflection of clinical practices and ethical values.

The changes required to more explicitly incorporate the ethical theory of autonomy involve a different response from the physiotherapy profession than a ‘compliance with professional duties’ approach. The question to be asked does not relate to what should be done in clinical practice in order to respond to ethical and legal requirements, but rather the more relevant question is what should be thought about when patients are given information and their informed consent is obtained. These changes are both profound and subtle. So subtle, it is unlikely they will be recognised in order to be incorporated without deliberate reflection and alteration of practice. So profound they have the potential to alter the underlying goals and purpose of the physiotherapy encounter.
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- *Sidaway v Bethlem Royal Hospital and Maudsley Hospital*, AC 871 (HL 1985).
- *Slater v Baker and Stapleton*, 2 WILS 359 (KB 1767).
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Summary report to first 10 participants

Dear Participant,

Thankyou for participating in my research project “How do Physiotherapists Understand and Discharge their Legal and Ethical Obligations to Obtain Informed Consent to Treatment?”

I enclose a report which summarises some of my current findings and interpretations of the data. I also enclose a copy of your treatment and individual interview transcript. I am interested in your comments on my report which is based on the audiotapes of the treatments and interviews of 10 physiotherapists including yourself. In particular, I am interested to obtain your comments and feedback about how well or otherwise my report fits with your opinions and experiences in everyday practice.

At the end of the report, I have enclosed a page where I invite you to agree, disagree or comment in any way. If you would prefer, I can ring and speak at a convenient time or come to your rooms for this feedback.

In a qualitative research project such as this, it is important to present findings which are representative of and have resonance with participants in the research. Your comments and feedback are therefore a necessary and significant component of the research. I would appreciate your help by completing the feedback section.

I have also enclosed a section where you can let me know whether you would like to continue to receive comments and reports as my research progresses.

Thanks again for your contribution to the research

Clare Delany
Research Report-background

This research is concerned with understanding the working experience and communicative actions of physiotherapists in private practice settings, and with the generation of a theoretical model for the communicative discourse of physiotherapy. Ethical and legal requirements of informed consent and patient participation in decision making will be examined, in the context of the conditions and circumstances of current physiotherapy clinical practice.

Both the law and ethical literature expect that information should be given to patients to enable them to make autonomous decisions. According to legal and ethical expectations, information should be relevant and understandable for the particular patient. It must contain information about risks, benefits and alternatives and the patient must voluntarily consent to any proposed assessment or treatment based on such information. Obtaining informed consent to treatment from patients forms one of many components of the communication between therapists and their patients. In order to examine the occurrence and significance of informed consent within the overall communicative discourse in a clinical encounter, I began with an examination of communicative action in private practice.

This research utilises qualitative grounded theory methodology, which is designed to generate or discover a theory closely related to the context of the study phenomenon. My study phenomenon is the communicative interaction within physiotherapy private practice settings. Typically, grounded theory, as a qualitative methodology takes a relatively small sample of participants and aims to generate analyses that are detailed and contextualised in nature. This means that I will look at what the physiotherapist and patient say to each other and ask questions such as “why was that said?” “what was the purpose of the conversation?” and what influences the communications in particular situations.

Phase 1: Participants

10 Physiotherapists

- Years since graduation ranged between 4 and 25 years
- 4 had postgraduate qualifications in manipulative therapy

Patients
• 6 patients were initial visits and 4 were return visits
• Acute back (2)
• Sports injuries (4)
• Chronic back (3)
• Sports assessment (1)

Findings

Four main categories of physiotherapy communication were identified in all treatment audio tapes:

1. Seeking information
2. Giving information
3. Giving instructions
4. Social conversation

Seeking information

Asking questions that imply that certain parts of the patient’s experience are more pertinent forms part of the physiotherapist’s role. It is a way of making their work visible to the patient. Although many of the therapists’ questions began with an open stem, such as ‘how can’, ‘how have’ and ‘what have’, 3 broad types of positions or identities adopted by the physiotherapists were identified.

Firstly, that the physiotherapist was there to help (physiotherapist as helper). Secondly, the physiotherapist was there to focus on a problem (physiotherapist as problem solver). Thirdly, that the physiotherapist was interested in the patient’s story (physiotherapist as listener or facilitator):
Physiotherapist as helper

*What can I do for you this afternoon (8) (first visit)*

*How can I help you today (12) (first visit)*

Physiotherapist as problem solver

*OK so you were saying it’s an old problem (10) (first)*

*So you are here for a point assessment (5) (first)*

*How did the bum go (6) (repeat)*

*Now can you have a seat and we’ll just go through what’s happened to you (11)*

Physiotherapist as listener/facilitator

*OK what have you got to tell me (9) (repeat visit)*

*Ok how have you been (4) (repeat visit)*

*How have you been since last week (7) (repeat)*

To a large extent, the opening question indicated a general theme for the style of communication which tended to be used in the whole of the treatment encounter. See Appendix 1 for examples of these categories and quotes.

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**Giving information**

**What information was provided to patients?**

The content of the information provided by all physiotherapists could be categorised as information about the:

1. proposed/actual treatment
2. proposed/actual assessment
3. the nature/cause of the problem

4. diagnostic/prognostic information

5. Patient management strategies

Although they are listed separately the participating physiotherapists often combined the information by making links between assessment findings, the nature of the problem and the proposed treatment. At other times, the therapists would provide only their conclusions about the assessment, diagnosis or management findings, rather than providing information which disclosed the process of diagnosis and reasoning about how the physiotherapist arrived at his or her decision.

**When was information provided?**

Information was provided at particular points in the treatment, but interestingly, never at the very beginning of the treatment. Rather, information was provided at the completion of a phase of communication. For example, after the subjective assessment and before the objective assessment, or before a treatment technique was given. These points of information giving were mostly initiated by the physiotherapist. They were aligned with the therapeutic goals of the treatment, either assessment, diagnosis and management and the purpose of the information was to enhance the patient’s cooperation with and understanding of the treatment process:

“In a general kind of patient I usually explain to them what I think the problem is, what I can do to help, what they can do to help and this is what I'm going to do to treat you. Any concerns?” (6-22)

“I'm very big on get to the heart of the problem and then explaining it very, very well because I think you get the most out of it then if they understand what's going on” (12-56)
Other influencing factors

Familiarity with the patient was another factor that influenced the style and content of the information. If the therapist believed that they had previously established rapport and/or if the outcomes of the treatment were successful, the flow of information was less structured, rather than at particular points in the treatment. In all the treatments, if the patient asked questions, the therapists would always respond to those questions.

What prompted the giving of information?

The therapists would pick up signals from the patients, often non-verbal ones such as facial expressions and their reactions to the treatment. Typically, therapists interpreted the needs of patients indirectly and rarely explicitly confirmed their interpretation with the patients.

Factors that prompted physiotherapists to provide information included:

- the stage of the treatment (as discussed above);
- familiarity with the patient
- physiotherapist’s intuitive assessment of the patient’s need for information:
  
  “If I get the impression that they are a little wary or unsure or anxious, I will give more explanation”

- alignment with functional/physical goals of treatment.

The following conversation between patient and therapist demonstrates how the therapist heard the patient’s concerns and responded (in this case using humour or making light of the patient’s concerns):

**Physio**: *Now come and sit, actually lie on your back here*

**Patient**: *All this is new to me. I was a bit nervous coming in*

**Physio**: *Oh yeah it’s a terrifying experience*
Patient: *(laugh)*

Physio: *What, you've never been to a physio before?*

Physio: *...and you know, it's not quite as medieval as ah...it depends on what you’re doing of course*

**Theoretical model – Giving information**

Central themes or core categories to emerge in the development of a theoretical model which accounts for (or gives plausible explanations for), physiotherapists’ communicative practices include the following:

- The physiotherapist has control of the content and agenda of the communicative discourse in the clinical encounter.

- Physiotherapists position themselves as an authoritative and expert figure whose role is to demonstrate a logical reasoning process and to look for, eliminate and verify problems.

- The content and purpose of the communication is aligned to the overall purpose of benefiting the patient (getting the patient better). The content and purpose of the communicative discourse is more aligned and consistent with the ethical principle of beneficence rather than the ethical principle of autonomy.

**Consequences**

There are 3 important consequences which relate to my research question, that flow from these central themes. Firstly, the role of the patient is generally to listen, to provide information, and to perform movements to aid the physiotherapist’s assessment. Secondly, there is a need for a degree of trust on the part of the patient, that is, trust in the therapist’s expertise. Thirdly, there are implications for the patient’s ability to give their informed consent to treatment within a clinical encounter where the communicative discourse is controlled by the therapeutic agenda of the physiotherapist.
Informed consent

The occurrence of informed consent within this description of communicative discourse was largely an indirect communicative action. As demonstrated above, physiotherapists directly give patients information about the assessment, treatment and management process. They were less direct about assessing the patient’s understanding of the information conveyed. Physiotherapists in the phase one group rarely asked directly or checked the patient’s understanding or interpretation of the clinical information. Therapists relied on their intuition and clinical judgment to assess the patient’s need for information. Whilst not following a formal procedure of obtaining a patient’s consent to treatment, the therapists often made their clinical reasoning thought processes visible to the patient. These processes indirectly gave patients the opportunity to agree, disagree, question or comment. Directly asking patients for feedback concerning the treatment or assessment, whilst it was occurring, was another opportunity for patients to contribute.

In summary, this first phase of the research raises questions and provides direction for the second phase:

What is the value and relevance of informed consent as it is defined in the ethical literature to the context of physiotherapy practice?

How do physiotherapists negotiate patient consent, or their involvement in clinical decision-making within a 30 minute consultation?

How compatible are the therapeutic goals of physiotherapy and the ethical goals of patient autonomy in clinical decision-making?

Feedback on first phase of the research

or phone (w)83444171
I would be interested in receiving further reports on this research in which I was a participant

Yes       □

No        □

Thankyou for your comments and involvement
APPENDIX 2

Questionnaire — Informed consent
How are the legal and ethical obligations understood
and discharged by physiotherapists?

Researcher: Clare Delany, physiotherapist and PhD student
Centre for the Study of Health and Society (CSHS), The University of Melbourne

This questionnaire is entirely voluntary. Your responses will remain anonymous.
Write in the space / box provided, or place a mark on the visual analogue scale.

1. Year of birth ........................................ 2. Gender ........................................
3. Year of physiotherapy graduation .................................................................
4. Place of graduation ............................................................................................
5. Have you any postgraduate qualifications? □ □
   If yes please state ..............................................................................................
6. Current area of physiotherapy work ....................................................................
   and in which country ..........................................................................................
7. (a) Have you read the 2000 Australian Physiotherapy Association pre-manipulative
     protocol on informed consent? Yes □ No □
     (b) Does the protocol apply to your area of work? □ □
     (c) Has the protocol or knowledge of the protocol changed the way you practice?..............
         .....................................................................................................................
8. Have any of the following sources of information increased your awareness of the legal obligation
   to obtain informed consent and/or caused you to change the way you practice:
   (You can tick boxes in either column) Increased awareness Changed practice
   (a) Professional publication? □ □
   (b) Professional courses? □ □
   (c) Conferences? □ □
   (d) Report of court decisions? □ □
   (e) Popular media? □ □
   (f) Informal discussion with others? □ □
9. When treating by **cervical mobilisation / manipulation**, do you think it important to tell the patient:

**The Benefits of treatment?**
- Very important
- Not important

**How the treatment works?**
- Very important
- Not important

**Alternative treatments?**
- Very important
- Not important

**Risks of the treatment?**
- Very important
- Not important

10. When treating a **grade 2 ankle sprain**, do you think it important to tell the patient:

**The Benefits of treatment?**
- Very important
- Not important

**How the treatment works?**
- Very important
- Not important

**Alternative treatments?**
- Very important
- Not important

**Risks of the treatment?**
- Very important
- Not important

11. When is it best to provide patients with information about risks of treatment: Yes No
   (a) after treatment? ☐ ☐
   (b) during treatment? ☐ ☐
   (c) before treatment? ☐ ☐

other ........................................................................................................................................................................
12. What method(s) do you use, or would you use, to give information to patients about cervical spine manual therapy (including manipulation):

(a) verbal
(b) handout
(c) videotape
(d) demonstration
(e) poster
(f) other (specify) ...........................................................

13. How significant are the following in your decision about how much or what sort of information to give to a patient about a proposed treatment?

**Time available to physiotherapist**

<table>
<thead>
<tr>
<th>Most significant</th>
<th>Not at all significant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language barrier</td>
<td></td>
</tr>
<tr>
<td>Most significant</td>
<td>Not at all significant</td>
</tr>
</tbody>
</table>

| Intelligence / education of the patient |
| Most significant | Not at all significant |

| Your assessment of patient's ability to understand information |
| Most significant | Not at all significant |

| Type of treatment to be given |
| Most significant | Not at all significant |

| Patient wants to know |
| Most significant | Not at all significant |

| Other factor(s) (specify) | .................................................................................................................. |

14. Do you think it is sufficient to use verbal means alone to obtain consent to treatment?  
Why? ........................................................................................................................................
15. Do you regard a physiotherapist as having a legal obligation to obtain informed consent:

<table>
<thead>
<tr>
<th>Verbal?</th>
<th>Written?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>(a) when a patient attends on referral from a doctor?</td>
<td>☐ ☐</td>
</tr>
<tr>
<td>(b) when a patient attends without a referral?</td>
<td>☐ ☐</td>
</tr>
</tbody>
</table>

16. Do you regard the obligation to obtain verbal informed consent before treatment as being: Legal? Ethical?

☐ ☐

Briefly state why? ........................................................................................................................................................................
......................................................................................................................................................................................................

17. Do you regard the obligation to obtain written informed consent before treatment as being: Legal? Ethical?

☐ ☐

Briefly state why? ........................................................................................................................................................................
......................................................................................................................................................................................................

18. How important is it to obtain informed consent prior to treatment in the following areas of work:

<table>
<thead>
<tr>
<th>Neurology practice</th>
<th>Important</th>
<th>Unimportant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic practice</td>
<td>Important</td>
<td>Unimportant</td>
</tr>
<tr>
<td>Sports medicine</td>
<td>Important</td>
<td>Unimportant</td>
</tr>
<tr>
<td>Cervical spine manual therapy (including manipulation)</td>
<td>Important</td>
<td>Unimportant</td>
</tr>
<tr>
<td>Cervical spine manual therapy (without manipulation)</td>
<td>Important</td>
<td>Unimportant</td>
</tr>
</tbody>
</table>
19. How important is it to teach the legal and ethical concept of informed consent in:

**an undergraduate academic program?**

<table>
<thead>
<tr>
<th>Important</th>
<th>Unimportant</th>
</tr>
</thead>
</table>

**a postgraduate academic program?**

<table>
<thead>
<tr>
<th>Important</th>
<th>Unimportant</th>
</tr>
</thead>
</table>

20. Which of the following statements comes closest to your own view of what, if anything, a physiotherapist should do to obtain informed consent before assessment or treatment:

(a) The physiotherapist should give the patient all the information that the *average* reasonable physiotherapist would ordinarily give?  

(b) The physiotherapist should give the patient all the information that the *average* reasonable patient would ordinarily need to know?  

(c) The physiotherapist should give the patient all the information that each particular patient would need to know?  

(d) How would you modify your choice, if at all, to make it more fully match your opinion?

21.

- Mary has been seeing John the physiotherapist for four treatment sessions following an acute episode of neck pain.
- John has used a combination of heat therapy and mobilisation of the upper cervical spine to relieve pain and muscle spasm.
- On the fourth visit John went through the physical screening tests advocated by the APA pre-manipulative protocol, and informed Mary that there were no contraindications related to manipulation and proceeded to successfully manipulate C 3/4 on the right.

(a) In your view, has John satisfied his **legal obligation**, if any, to obtain informed consent to manipulation?  

(b) In your view, has John satisfied his **ethical obligation**, if any, to obtain informed consent to manipulation?  

(c) Is there anything else John could or should have done?

...........................................................................................................................................................................
22. What is your view of the significance of informed consent in the physiotherapist/patient relationship, and how the profession has handled it so far?

Thank you for taking the time to complete this questionnaire
APPENDIX 3

Physiotherapists and patients: Demographic Information

1. Tom graduated nine years ago. His past experience has been in private practice settings and overseas and he has no formal post-graduate qualifications. Tom’s patient was a female in her early 40’s who is a factory worker and drives a forklift. She works ten hour shifts and her main problem is neck pain. I recruited Tom via a suggestion from a colleague at the University. Tom chose this patient because he felt comfortable with her (this was her third treatment) and he thought that she would not mind the tape recorder being present.

2. Karen graduated four years ago. She has no formal post-graduate qualifications. Karen was recruited on the basis of convenience to me as she was a part-time member of staff at the University. Karen chose her patient out of convenience to her timetable of patients for the day. Her patient was a 12 year old girl. The patient was presenting for an assessment of fitness and flexibility for her sport accompanied by her mother.

3. Aaron graduated six years ago. His experience has been in private practice and sports therapy and he has completed a Masters degree in manipulative therapy. Aaron was recruited through my acquaintance with him as a teaching colleague. Aaron chose his patient because he knew him well and had seen him several times previously for different problems. Aaron’s patient was a 27 year old male amateur soccer player returning for assessment following cortisone injections for hip bursitis (inflammation).

4. Jean graduated twenty five years ago and completed a post-graduate qualification in manipulation ten years ago. I recruited Jean via the publicly available booklet. Jean chose her patient because she thought that the patient would not mind having the treatment recorded. Jean had treated this patient on one other occasion. Her patient was a seventy three year old woman who was a carer for an autistic child and her husband with Parkinsons disease. The patient’s main problem was sacro iliac joint pain and leg pain.

5. Rebecca graduated twenty one years ago and has a post-graduate Diploma in manipulative therapy and a masters in research. She has had general hospital, private practice and clinical teaching experience. I recruited Rebecca on the basis of her past experience and expertise in both teaching and clinical practise. Rebecca recruited a new patient because she thought that there would be more information exchanged between herself and a new patient. Her patient was a woman in her early 40’s who presented with calf pain.
6. Leon graduated nine years ago and he has no formal post-graduate qualifications. I recruited Leon through the publicly available booklet. His past experience has mostly been in private practice. His patient was a 30 year old man injured at work three years ago who has had a discectomy six months ago. The patient had been previously seen by physiotherapists up to twenty times previously and was now coming every three months for exercise and self-management guidance.

7. Ian graduated seven years ago and is currently undertaking post-graduate research. His experience has been in private practice and his patient was a woman in her early 30’s who was normally very active and presented with an acute recurrence of stiffness and pain in the lumbar spine. I recruited Ian via a colleague who knew of Ian’s practise.

8. Ray graduated twenty three years ago and has a post-graduate Diploma in manipulative therapy. His experience has been in private practice. His patient was a man in his early 30’s who had sprained his ankle playing basketball. Ray recruited his patient because he was a new patient and he thought that there would be more formal interaction with a new patient rather than a returning patient.

9. Saul graduated fourteen years ago and has a post-graduate Diploma in manipulative therapy. His experience has been in private practice and sports therapy. His patient was a woman who was in her early 30’s who was normally very active and attended Pilates classes and kick boxing, where she sustained a hamstring tear. I recruited Saul via the publicly available booklet.

10. Catriona graduated six years ago and has worked in both private practice settings and sports medicine centres. Her patient was a 30 year old woman with acute low back pain. This was her second treatment with Catriona.

11. Adam graduated five years ago and had no formal post-graduate qualifications. His experience has been in private practice. His patient was a man in his late 50’s who had strained his right shoulder. This was his second treatment with Leon. I recruited Adam because Adam was a relatively recent graduate and I was interested in the views and practices of a younger therapist.

12. Craig graduated eighteen years ago. He had completed a masters in manipulative therapy six years ago. His patient was a 30 year old man with low back pain. Craig had seen this patient six times previously. Craig recruited this patient out of convenience to his daily timetable. I recruited Craig because of the nature of his practice. Most of his patient had been injured at work and were receiving payments for their injury through the workers’ compensation scheme.

13. Vera graduated twenty four years ago and has a post-graduate diploma in manipulative therapy. I recruited Vera because she has been actively involved in both clinical teaching and the professional
association for a number of years. Her background has been in private practice and her patient was a 45 year old man with low back pain. Vera had seen this patient once before. She recruited this patient because she thought he would not mind having the treatment audiotaped.

14. Joseph graduated eighteen years ago and has a Masters in manipulative therapy. I recruited Joseph through the publicly available booklet. His patient was in her mid-30’s, a woman with thoracic back pain following delivery of her first child and this was her first treatment. Joseph recruited this patient out of convenience to him.

15. Linda graduated twenty four years ago and has a post-graduate diploma in manipulative therapy. Her patient was a 45 year old man with low back pain and this was his second treatment. I recruited Linda because of her particular interest and involvement in setting guidelines for practice for patients receiving workers compensation payments.

16. Seth graduated five years ago with no post-graduate qualification. I recruited Seth from the publicly available booklet. His patient was a 14 year old girl with knee pain and this was her first treatment. Seth recruited his patient out of convenience to him.

17. Sean graduated twenty years ago and has a masters in manipulative therapy and research. His patient was a 75 year old man with low back pain and this was his first treatment. I recruited Sean from the publicly available booklet because he was in a sole practitioner.
Descriptive statistics and graphs of results of questionnaire

Figure 2 Proportion of all respondents, (including current and non-current users of cervical spine manual therapy) who indicated they had read, found applicable and been influenced by the APA pre-manipulative therapy guidelines (2000).
Figure 3 Comparison of all respondent’s ratings of the comparative importance of information provision for cervical manual therapy (high risk treatment) and ankle sprain (low risk treatment).
Figure 4 Comparison of all respondents’ ratings of the comparative importance of the need for informed consent across different treatment categories by all respondents.

![Bar chart showing comparisons of consent ratings across different treatment categories](chart.png)
Influence on information provided (VAS rating)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pt's wishes</td>
<td>73.8</td>
</tr>
<tr>
<td>Treatment type</td>
<td>72.4</td>
</tr>
<tr>
<td>Pt's understanding</td>
<td>61.8</td>
</tr>
<tr>
<td>Time available</td>
<td>46.7</td>
</tr>
</tbody>
</table>

**Figure 5** Factors influencing all respondents’ choice of type of information given to patients.
APPENDIX 5

Patient assessment form used in postgraduate education at the School of Physiotherapy, The University of Melbourne.
APPENDIX 6

Publications
Informed consent: Broadening the focus

Clare Delany
The University of Melbourne

In Australia, the landmark case of Rogers v Whitaker (1992) 175 CLR 479 clarified the law relating to the duty of health professionals to provide information to patients. In responding to these developments in the law, the Australian physiotherapy profession has sought to define and articulate the scope of this legal duty as it relates to physiotherapists and to specific physiotherapy treatments, in particular cervical manipulation (Mann and Refshauge 2001). The response has been to focus on the duty discussed by the courts rather than on the emerging underlying issues of shared decision-making and patient empowerment.

The profession’s adoption of a defensive position could be described as the donning of a legal “flak jacket” (Jones 2001). That is, by practising within the protective armoury of evidence-based clinical efficacy and appropriate educational qualifications, physiotherapists perceive they will be better equipped to deal with any legal threat and patients will also be in safer hands.

Whilst there is clear merit in this approach for both patient safety and quality clinical practice, it is a disappointingly narrow perspective from which to form the basis of information disclosure practices in the clinical encounter. The “flak jacket” response does not assist clinicians to negotiate decisions which incorporate the patient’s wishes or understanding in relation to a proposed treatment. If adopted, it places a defensive and minimalist approach to what can and should occur in discharge of the legal and ethical obligations of information disclosure within physiotherapy practice. In short, such an approach effectively ignores the ethical basis underlying the provision of information by distancing the action of information disclosure and informed consent from the moral theory of respect for a patient’s autonomy and ability to make an autonomous and informed decision.

There are three broad explanations that may account for a physiotherapist or other health practitioner providing information to a patient for the purpose of gaining their informed consent to treatment. The first explanation may be because it is recognised by the practitioner as part of his or her ethical duty to respect a patient’s autonomy and/or act in the best interests of the patient. The second explanation may be because the practitioner is aware of the inherent clinical value of giving patients information and obtaining their informed consent to the proposed treatment, for the purposes of compliance, co-operation or adherence to the treatment regimen. Third, the act of providing information and obtaining consent may be motivated by knowledge of the law, which demands that information be provided such that the patient is in a position to make an informed decision. In the latter context, obtaining informed consent is viewed as a legal obligation, which must be fulfilled, or a ‘hurdle’ rather than, and separate from, objectives of improved and enhanced patient outcomes, consistent with the traditional goals of health care practice.

From an historical ethical perspective, the amount of information a health care practitioner provided to a patient was related and subsumed into the goals of health care, formulated in terms of beneficence, which, in turn, was narrowly interpreted, understood and defined by the practitioner’s professional opinion (Cox White and Zimbelman 1998). Concomitant with this ethos, ethical justification of information provision would have been sufficient if a physiotherapist thought that certain information would be beneficial to the therapeutic outcome in terms of patient adherence, compliance and understanding. “Gaining the patient’s confidence and cooperation” is a mantra etched in the memory of undergraduate physiotherapy students of the Seventies and Eighties. It is a mantra that sought to serve the purpose of achieving both the established ethical and clinical goals of treatment.

In the last three decades, in the bioethical literature, the notion of information provision and informed consent has been framed in the emerging language of patient rights, patient empowerment and patient self-determination. The definition of informed consent from this contemporary ethical perspective is the autonomous authorisation of a patient for a proposed procedure (Beauchamp and Childress 1994). The requirement of a physiotherapist who provides information to a patient, based on these ethical ideals, involves the provision of information which offers meaningful and relevant choices. Information is required to be both intellectually and emotionally comprehensible to the patient. It should, in addition, be provided without any other controlling or coercive influences, allowing the patient freedom or autonomy of choice.

Traditionally, the law governing the clinical encounter has had a more narrow focus with the concepts of informed consent and patient autonomy. It has been centred upon respect for a patient’s autonomy and autonomous choice in the context of how the ability to choose, and the exercise of that choice, impacts on issues of liability for subsequent preventable injury to a patient (Faden and Beauchamp...
Editorial

1986). From this perspective, legal disclosure requirements are influenced by legal theories of liability and practitioner responsibility, which delineate an obligation to make disclosures rather than the broader ethical and clinical meaning that information disclosure may have (Kerridge and Mitchell 1994).

The desire to prevent breach of duty is reflected in the physiotherapy literature, which has similarly sought to delineate practitioner responsibility relating to effective clinical screening and information provision requirements when a treatment has a recognised associated risk such as that relating to cervical manipulation. Subsequent research has focused on professional compliance with the published guidelines.

In 2000, the APA pre-manipulative testing protocol (originally established in 1988) was reviewed, on the basis of the findings of a survey conducted by the Manipulative Physiotherapists Association of Australia (Magarey et al 2000a) and current research outcomes. According to the survey, compliance with the protocol of screening and gaining informed consent was poor (Magarey et al 2000a). Many of the respondent manipulative therapists thought the protocol of objectively screening patients was cumbersome and (despite the legal necessity to do so if the “flak jacket” was to have a real prospect of providing protection) many members failed to comply.

Intra-professional discussion which followed the publication of the revised guidelines (Magarey et al 2000b) has focused on the capacity of physiotherapists to make sound clinical judgments where treatment carries some risk, based on educational qualifications and the application of adequate screening procedures. In 2001, a commentary on the APA guidelines in this journal acknowledged uncertainties confronting the clinician seeking to reliably predict risk factors in patients prior to manipulation (AJP Forum 2001). Concerns expressed included the use of screening tests that have inherent reliability, validity (and safety) limitations (Dunne 2001), the difficulty of identifying with accuracy the real risk of manipulation (including the various methods of application) (Reid and Hing 2001), and the relative risk of mobilisation treatment without manipulation (Schneider 2002). There was also concern expressed as to the effect on legal liability of following or not following the APA guidelines (Mann and Refshauge 2001). More recently, there has been further discussion as to what constitutes suitable qualifications to practise manipulation, with some authors suggesting that educational requirements should be specialised and restrictive to maximise safety and care for patients (Refshauge et al 2002).

The discussion of these issues of informed consent prior to cervical manipulation on the basis of patient safety, professional compliance and evidence-based clinical practice has taken place in the context of developments in the law and a perception that the profession should take steps to guard against exposure to legal action. Whilst this response is a professionally responsible one, it is also one that fits the third explanation of information provision above, that is, one which can be analysed in terms of guiding rules and social obligations (Beauchamp and Childress 1994), or as a legal ‘hurdle’ to be overcome, in itself somewhat marginal to the true goals of physiotherapy practice and narrow rather than broad in its focus.

The response need not and should not be so narrow. Recognition of the broader objectives of enhanced treatment outcomes fostered by a recognition of patient autonomy and right to informed decision making is consistent with discharge of more narrowly based legal obligations.

Several authors have devised guidelines and models of communicative practice for medical practitioners in an attempt to forge meaningful links between the ethical theory of respect for a patient’s autonomy and the practical action of providing information to patients and obtaining their informed consent. For example, Katz (1984) emphasised a model based on conversation and encouraged physicians to see informed consent as a genuinely mutual and participatory process similar to a conversation, whereby practitioners are willing to both confront and change their views of themselves as the sole authority and of their patients as unable to competently make medical decisions. A commitment to a conversation model would mean that physiotherapists would have to acknowledge their uncertainties and lack of evidence-based knowledge, and shortfalls and limitations of screening procedures and the like, which is a part of all health care practice, when disclosing information and gaining patients’ consent. Brody (1999) uses the strengths of the conversation model developed by Katz (1984) and operationalises them in his transparency model. The transparency standard does not key to adherence to a list of risks and benefits that a hypothetical reasonable patient would want to know, or to existing standards of other practitioners but rather, according to this model, disclosure standards and content are “adequate when the physician’s basic thinking has been rendered transparent to the patient” (p. 97). Transparency of communication means that the physiotherapist would need to share his or her thinking with the patient, encourage questions, discover how participatory the patient wishes to be and facilitate that level of participation. Wear (1998) believes the informed consent debate should be placed within the context of the realities, needs and opportunities of the physician/patient encounter, and should be aligned with the goals of the treatment encounter. In Wear’s view, information disclosure and informed consent are central to the goals of an effective treatment encounter, rather than a marginal legal requirement.

Taking this broader, transparent approach necessarily involves a clear explanation to the patient of the risks and benefits of what is proposed and is likely to go a considerable way toward discharge of information provision obligations which the law demands. Combining this approach with the conversational model means that the consent is likely to be meaningfully achieved at a level and on a basis suited to the patient’s individual needs.
Writing for physiotherapists, Coy (1989) suggested that the implication of informed consent or information disclosure to a patient, which is based on the moral principle of autonomy, is that provision of information to a patient and obtaining his or her consent is required not only for potentially risky procedures, but also for procedures that are generally perceived to be less risky or low risk. Coy states: “When informed consent is based on the importance of protecting or enhancing autonomy, it is required because of the potential infringement on autonomy, regardless of whether a potential for harm exists” (p. 829).

Adopting a broader approach to obligations of information disclosure and informed consent is likely to improve patient/therapist relationships and facilitate other treatment outcomes such as: identification of both patient and therapist treatment goals; identification and enhanced responsiveness to patients’ misconceptions, fears and false hopes; a decrease in the burden of responsibility on therapists to assume control for the complete cure of patients’ problems and enhancement and empowerment of patients’ abilities to use self-management strategies.

Whilst the physiotherapy profession is to be commended for its professional response to the legal issue of informed consent, it must also be brave enough to remove its defensive armour and to incorporate and embrace the broader ethical meanings of information disclosure and informed consent in clinical practice. Effective procurement of a patient’s informed consent is merely one aspect of a meaningful and effective clinical encounter where sound communication skills and techniques are employed between therapist and patient.

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**References**


This article discusses methods and mediums of obtaining informed consent in physiotherapy clinical practice, specifically in relation to cervical manipulation. Whilst cervical manipulation is a useful method of treatment for spinal joint pain and dysfunction, it has also been shown to be ineffective or even positively harmful. Legal precedents have set boundaries for informing patients of such adverse consequences. However, a degree of uncertainty exists in the physiotherapy profession, as in other health care professions, as to how to obtain informed consent in a busy clinical setting in order to discharge the legal duties owed. Obtaining meaningful informed consent in clinical practice raises issues of patient comprehension, memory and decision-making capacity. A large quantity of research directed at enhancing patient understanding has been undertaken in recent years. The important findings are that a variety of communication methods and mediums need to be employed in both providing information and assessing patient understanding. A combination of verbal, written and audiovisual information provides patients with maximum opportunity to be involved in treatment decisions.
Cervical manipulation is defined as a small-amplitude movement of a cervical spine joint or joints, delivered manually by a clinician to a conscious co-operating patient, but delivered at a velocity which the patient cannot voluntarily prevent.1 Physiotherapeutic cervical manipulation is an elective procedure, and patients who have cervical pain and/or movement dysfunction may choose from a number of other, less intrusive physical treatments. Cervical manipulation is not the only treatment procedure available to treat their physical symptoms. It is one method of moving joints of the cervical spine in order to relieve pain, joint stiffness and/or muscle spasm, a treatment methodology the effectiveness of which is supported by objective evidence of benefits for neck pain and headaches.2 Cervical manipulation is not always a suitable method of treatment. Sometimes it may exacerbate an individual’s symptoms and some individuals have predisposing factors that contra-indicate or make them unsuitable to the use of manipulation.3 It is also not possible to predict every individual at risk of complications following manipulation.4

Recent clinical studies of manipulation have concluded that cervical manipulation applied to patients in good health for relatively minor conditions such as cervical headaches and neck pain has occasionally produced devastating adverse events such as quadriplegia, stroke or death5.6

Whilst cervical manipulation can cause severe neurological complications, they are exceedingly rare and generally unpredictable.6 Reports of risk of stroke following manipulation of the cervical spine vary from 1:163,000 to 1:1,000,000,7 and more recently 1:4,500.8 Given the associated risk, the practice of cervical manipulation highlights the practical steps physiotherapy practitioners are required to take in order to discharge the legal obligation of obtaining patients’ informed consent before administering this treatment. A physiotherapist, having adequately screened a patient for factors that would contra-indicate manipulation, and having performed the manipulation with reasonable skill, may still leave the patient at risk of an adverse event undetectable prior to the treatment. The legal issue of failure to warn often arises when, in fact, the physical cause of the injury was not related to practitioner negligence.9

Legal obligations

The most significant case in Australia regarding the duty to obtain informed consent is Rogers v Whitaker.10 Mrs Whitaker undertook elective ophthalmic surgery to the right eye. When considering whether to have surgery, she questioned her doctor closely about possible complications. There was a remote risk, 1:14,000, of which she was not told, that the operation to her right eye could affect her left eye. The risk eventuated and she was left totally blind. Mrs Whitaker succeeded in the New South Wales Court of Appeal and in the High Court on the basis that the doctor had a duty to warn her of the risk, and had breached that duty. Liability for breach of duty was established on the facts, given the failure to warn.

In the more recent case of Rosenberg v Percival11 the surgery was performed by a dental surgeon. The
Cervical Manipulation – How Might Informed Consent be Obtained Before Treatment?

Patient, Dr Percival, subsequently suffered from severe temporomandibular joint complications including chronic, severe and disabling pain. In this case the dental surgeon was successful. However, all members of the High Court in Rosenberg v Percival affirmed that a health care practitioner owes a duty to warn patients of material risks inherent in proposed treatments. In relation to methods of communication between doctor and patient, Kirby J noted that the provision of written information by the appellant to the patient was to be commended. However, he added that “such forms were no substitute for dialogue between patient and surgeon”. Kirby J also referred to the importance of “shared” decision-making and consent that is “truly understood” by the patient.

In Rogers v Whittaker, and more recently Rosenberg v Percival, the High Court has expressed the clear view that decision-making within medicine must be:

“a shared exercise in which health care practitioners are obliged to take active steps to ensure that patients are empowered to make their own decisions about important procedures to be undertaken on their bodies”.

Retsas and Forrester refer to the general legal principle underpinning the findings of the High Court in Rogers v Whittaker as follows:

“the paramount consideration is that a person is entitled to make decisions about his or her own life, and the duty to disclose the information takes its precise content from the needs, concerns and circumstances of the patient.”

Legal requirements have deviated from what some health practitioners have regarded as a unidirectional, dutiful disclosure of alternatives, risks and benefits. Now there is an expectation of a meaningful exchange of information between patient and health care practitioner. The necessary elements therefore for obtaining informed consent are broader than a bureaucratic legalism, or, as one author suggested, “consent forms which include the kitchen sink as well as every other known, unknown or suspected risk”.

**Informed consent and clinical practice**

A 1997 study of audiotaped primary care visits between patients and doctors identified the following key elements of informed consent in clinical practice:

- discussion of the clinical issue and the nature of the decision to be made;
- discussion of the alternatives;
- discussion of the benefits and risks of alternatives;
- discussion of uncertainties associated with the decision;
- assessment of the patient’s understanding; and
- asking the patient to express preference.

The study found that, although important clinical decisions were commonly made, they were rarely preceded by substantive discussion of the elements of an ideal informed consent. The least frequently included element was assessment of the patient’s degree of understanding.

Effective exchange of information between doctor and patient is recognised as a crucial component of the consultation. Since physiotherapists have many of the traditional diagnostic and prescriptive roles of the doctor, they are also directly accountable to their patient. In some circumstances they may also be accountable to the patient’s doctor or other members of a health care team. The patient-to-clinician information exchange process is as important for the physiotherapist as the doctor. This is particularly so where patients attend a therapist without a referral from a doctor, an increasingly common practice. Initially, such patients cannot be presumed to have any real understanding of treatments proposed or their associated risks.

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17 Rosenberg v Percival (2001) 205 CLR 434 at [148].

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Within both clinical health care practice and research, obtaining informed consent from the patient/subject is expected. Increased emphasis upon, and changing policy with respect to, informed consent amongst all health care practitioners has resulted in standards of practice being evaluated not simply in terms of the treatment outcome (measured by changed physical signs and symptoms), but also the information-giving behaviours of the health care practitioners.

The Australian Physiotherapy Association (APA) has recently reviewed its pre-manipulative screening guidelines. These guidelines include procedures for subjectively and objectively screening patients for risk factors. They also include the components of obtaining informed consent separated into provision of information and gaining consent:

4.1 Provision of Information

- It is essential that physiotherapists provide patients with information about procedures to be used in treatment, in particular, manipulative techniques.
- Information may be provided orally by the physiotherapist or in an information sheet/brochure, to ensure that the information is standardised, in the initial instance. Such information, whether delivered orally or in a brochure, must cover the following:
  - information about the procedure
  - alternatives to the proposed treatment
  - benefits and risks of the proposed procedure
  - the opportunity to ask questions
  - the opportunity for the patient to change his/her mind during the procedure (where practical)
  - the opportunity for the patient to take time to reflect on the information provided before agreeing to the procedure.”

The APA guidelines broadly reflect the care and detail of explanation of risk expected of a competent physiotherapist performing cervical manipulation. Adherence to standards of conduct set by one’s peers does not, however, result in absolution from risk. Ultimately it is for the court to determine whether what was done contravened the duty. Nevertheless, the court will not ignore published professional standards in determining whether sufficient information regarding risk was given to a particular patient. The court will also consider whether the information was expressed in such a way as to be understood by that particular patient.

The pre-manipulative guidelines may add to physiotherapists’ uncertainty about how to satisfy their legal obligation to obtain a patient’s consent prior to manipulation. On the one hand, the guidelines emphasise the importance of performing adequate screening tests prior to the physiotherapist’s decision to manipulate; that is, they endorse the need for clinicians to use objective clinical reasoning skills when deciding on a course of treatment. Commenting on the guidelines, one author said the decision to manipulate (still) lies ultimately with the physiotherapist. On the other hand, there is little practical guidance on the method of assessing a patient’s understanding or upon meeting an individual patient’s requirements for information.

Many of the cases where the courts have had to determine the adequacy or presence of informed consent in a clinical encounter have involved the performance of invasive or risky procedures by surgeons. For physiotherapists, however, these surgical cases, whilst giving guidelines as to the standards required by law, are removed from physiotherapy’s primary-care style of practice. Physiotherapists in private practice generally see patients every 20 to 30 minutes. The decision to use manipulation often occurs following assessment, or following review of the effects of another technique, all within the 20- to 30-minute treatment period.

Unlike elective surgical procedures, physiotherapists’ patients are usually not sent home with information about the procedure so that they can consider the pros and cons of the treatment. Gaining an ideal informed consent in the physiotherapy setting, as needed to discharge the legal duty owed, may therefore be seen by

27 Braddock et al, n 18; Rogers v Whitaker (1992) 175 CLR 479.
physiotherapists as difficult or impractical to achieve.

As part of the review and development of APA guidelines, a survey of compliance of members of the Manipulative Physiotherapists Association of Australia (MPAA) with the current protocol was undertaken. It demonstrated that a high percentage of “manipulative physiotherapists” (physiotherapists with postgraduate training in manipulative therapy) use cervical manipulative techniques regularly (with low incidence of complications). However, compliance with the protocol of screening and gaining informed consent was poor. Many of these manipulative therapists thought the protocol of objectively screening patients was cumbersome, and, despite the legal necessity, many members failed to comply with the need for informed consent.

In 2001, a commentary on the APA guidelines in the Australian Journal of Physiotherapy acknowledged uncertainties confronting the clinician seeking reliably to predict risk factors in patients prior to manipulation. Concerns included the use of screening tests that have inherent reliability, validity (and safety) issues in themselves, and the difficulty of identifying with accuracy the real risk of manipulation (including the various methods of application). There was also concern expressed as to the effect on legal liability of following or not following the APA guidelines.

The APA guidelines in their present format provide clinicians with evidence-based information on the use and value of screening tests prior to using cervical manipulation as a part of treatment. However, they do not address the method of engaging and involving the patient in the decision-making process, other than to acknowledge that it is necessary to assess each patient’s level of understanding.

In their annotated bibliography on informed consent, Sugarman et al identify similar uncertainty in a number of related empirical areas including:

- how/whether meaningful consent is achieved;
- whether theoretical (legal and ethical) understandings of informed consent are useful or practical; and
- what practices facilitate patients providing meaningful consent to assessment and/or treatment.

Having accepted the validity of obtaining informed consent in order to discharge legal obligations, in this article the present author will address the first and third areas identified by Sugarman et al, particularly highlighting the most effective methods, styles and medium of information exchange between therapist and patient, based on current and past studies in this area.

The ability to communicate so as to achieve informed consent must be considered an essential ingredient of good patient care. Physiotherapists, like other health care professionals, who lack the skills to inform patients appropriately so as to discharge their obligations, must be viewed as lacking essential clinical skills necessary for practice.

From a practical clinical perspective, in order to obtain informed consent prior to cervical manipulation, the elements identified previously can be divided into two main tasks. The first task is to inform patients about the known risks and benefits of cervical manipulation. Physiotherapists must therefore have up-to-date knowledge of the potential effects of manipulation, both favourable and unfavourable, for each individual patient. They must be able to present them to the patient in a clear and concise way. This may require repeating or elaborating them often during a 20- to 30-minute treatment session.

The second task is to gain the (meaningful) consent of the patient. Physiotherapists’ communication skills must enable them to assess the patient’s understanding of the information, so that the patient’s consent to the treatment is obtained in a manner consistent with the discharge of the legal obligation.

What is laudable and apparently straightforward in theory is not always easily discharged in practice.
Informed (that is, meaningful) consent requires that patients assess the relevant risks and benefits of a proposed intervention and then voluntarily give permission to proceed. Such criteria raise issues of patient comprehension, memory and decision-making capacity. They also raise issues concerning the health practitioners’ knowledge of legal and ethical obligations, and their propensity to honour these obligations. The legal requirement that patients should understand the information, advice or warnings places the onus squarely on the treating practitioner to individually tailor the information.

**Style of communication**

Information-giving has been identified as one of the primary activities of physicians during the medical visit. Some kinds of information are more dramatic and significant than others. The way in which information is delivered to patients can have far-reaching consequences in terms of patients’ responses and acceptance. For example, “I wish to manipulate your cervical spine; there is a small risk you could die”, is a clear example of shock tactics. Similarly, some treatment decisions to be made by patients are more complex than others, involve more risks, or have more alternatives to discuss.

Cervical manipulation is one method available to a therapist to treat neck, head and referred upper limb pain. Other alternatives include exercise, manual muscle therapy and electrotherapy. To discharge legal obligations physiotherapists should not just focus on the risks but highlight treatment alternatives. The warning only of death is overly dramatic if the patient’s perception is a choice only between continuing pain and dysfunction and death from manipulation.

No adequate guidelines exist for how much discussion is required for the completeness of informed decision-making concerning issues of varying complexity. More guidance is required than just to say that what will be required varies with the individual patient symptoms, the individual characteristics of the patient, and apparent level of comprehension of language, concepts and treatments. Several studies of the effects of different styles of physician communication behaviour assist physiotherapists in determining what is most likely to be effective as a medium of communication irrespective of individual patient idiosyncrasy.

The clinical setting is a time-constrained environment influenced both by economics and sheer workload. This leads inevitably to shortcuts. A study by Beckman et al found that physicians interrupted patients’ statements and directed questions towards a specific concern in 69 per cent of the 74 primary care visits investigated. The authors argued that premature interruption and the use of controlled style information-gathering, resulted in some loss of information exchange.

The importance of a more open style of communication has also been identified in a study of patients’ views on their discharge from an outpatient clinic. The key themes that emerged from interviewing 43 patients centred on the importance of the doctor acknowledging the right of the patient to information about his or her future treatment and prognosis. Patients appreciated having their concerns and views taken seriously. If they did not understand why they were being discharged, they often constructed their own explanations. The authors concluded that a communication style that acknowledges the validity of patients’ knowledge and makes it possible for patients to take a more active role is the most appropriate, especially in more chronic health problems. Patients tend to carry out their own “cost-benefit” analysis of a treatment, weighing up the

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38 Burkey, Black and Reeve, n 39, at 1138.

39 Beckman et al, [SO] add “treating” “especially when treating more…”
costs/risks of each treatment against the benefits as they perceive them.\textsuperscript{41}

The discharge of a legal obligation is not an anathema to either a successful consultation outcome or a satisfied patient. A 1996 study measuring quality and quantity of information giving to inpatients who had been discharged from general wards of a hospital revealed two main causes of positive patient comments.\textsuperscript{32}

1. when information was particularly clear, personalised and helpful; and

2. when lay language was used and patients were given a chance to ask questions along with time to understand what was said.

From the patient’s perspective, one main barrier to positive communication is the inherent difficulty in obtaining a match between patient expectations of health care professionals who will listen to them, and treat them with respect as a person, on the one hand, and, on the other, the professional who assumes patients to be compliant and passive regarding advice and treatment.\textsuperscript{43}

Effective information exchange is not just verbal expression, but presentation of information such that it is acceptable to the patient\textsuperscript{44} and fits with the patient’s sense of values.\textsuperscript{45}

Acknowledgment of the patient’s view and understanding of information requires mutual trust.\textsuperscript{46}

The following styles have been identified in the literature as satisfying legal obligations of information exchange whilst facilitating communication:

- Patients need to complete their opening statements of concern.\textsuperscript{47}

- Patients’ concerns and views need to be taken seriously.\textsuperscript{48}
- Information given needs to be tailored to the needs of the patient and accessible to them.\textsuperscript{49}
- An atmosphere of mutual trust needs to be created.\textsuperscript{50}
- Open questions by the health care practitioner encourage greater disclosure of information from the patient.\textsuperscript{51}

The essential message which each of these points raise concerning communication is that an interpersonal relationship must exist between the health care professional and the patient.

**Verbal communication**

The most obvious and traditional method of communication in the clinical encounter is verbal. Verbal communication between doctors and patients has been studied and reported extensively and provides a useful parallel experience for physiotherapists.\textsuperscript{42} The literature points to three significant components of effective verbal communication between practitioner and patient:

1. the verbal communication style impacts on the effectiveness of the information exchange;

2. the timing of information presentation is important; and

3. when giving verbal information to the patient it is important to assess the patient’s current knowledge and perceptions and verify that the patient has correctly assimilated/interpreted the information given.

Added to these factors is an increased effectiveness where written information is also provided.

Studies of physiotherapist-patient communication reveal similar findings to doctor-patient studies. Interviews of four disabled people were analysed, focusing upon the patients’ attitudes to physiotherapists.\textsuperscript{53} In this study, good experiences of physiotherapy were associated with a

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\textsuperscript{41} J L Donovan and D R Blake, “Patient Non-compliance: Deviance or Reasoned Decision-making” (1992) 34 Social Science and Medicine 509.


\textsuperscript{43} Cortis and Lacey, n 42, at 676.

\textsuperscript{44} Beate et al, n 20, at 384.


\textsuperscript{48} Keller and Carroll, n 47; Beate et al, n 20.

\textsuperscript{49} Burkey, Black and Reeve, n 39; Roter and Frankel, n 36; Karlawish, n 45.

\textsuperscript{50} Beate et al, n 20; Keller and Carroll, n 47; Karlawish, n 45.

\textsuperscript{51} Roter and Frankel, n 36; Beckman, Frankel and Darnley, n 38; Keller and Carroll, n 47.

\textsuperscript{52} D Roter, J Hall and N Katz, “Patient-Physician Communication: A Descriptive Summary of the Literature” (1988) 12 Patient Education and Counselling 99; see also Ong et al, n 23.

personal approach; that is where the patients felt their needs as a person were being met. Physiotherapists, like other health care practitioners involved in physical diagnosis, rely on a physical and symptom-oriented approach. Diagnoses can be made and diseases defined without reference to individuals and their social context. In the case of cervical manipulation, symptoms are usually well-defined and physically based. Hence physiotherapists may not necessarily feel a need to assess broader social aspects of a particular patient who presents with neck pain or stiffness. This style of practice was illustrated by a study in which basic interviewing skills used by 14 specialist manipulative physiotherapists were identified during the interview component of the initial assessment. Six basic interviewing skills were identified from the transcripts of the interviews: closed inquiry; open inquiry; minimal encouragement; paraphrasing; giving information; and giving opinion.

Closed questions scored the highest percentage value within the range of identified interviewing skills. Whilst the relatively high score of closed questions may be accounted for in the context of clinical reasoning, assessment skills and the nature of diagnostic clinical behaviour, such high scores do not sit well with the elements of ideal informed consent previously outlined by Braddock and legally required by the High Court.

In a study of 227 audiotaped treatment sessions involving physiotherapists, some kind of patient education was included in 85 per cent of these sessions. In this study, however, Sluijs also found that therapists seldom asked patients to discuss their perceptions of the problem. In a more recent study that investigated dominant forms of interaction between physiotherapists and patients in treatment of strokes, Talvitie and Reunanen found that the physiotherapists hardly ever talked to patients about the goals of therapy, and these patients were allowed little opportunity to take the initiative in their treatment. Whilst treatment of a patient with neck pain in an outpatient setting presents a different scenario to that of rehabilitative treatment of a stroke patient, the findings suggest that physiotherapists may need to change their communication styles in order to fulfil legal obligations of information exchange.

The timing of information

Many patients suffer from pain and/or anxiety about their perceived problems at the start of treatment. They may be worried about the significance of the symptoms and prognosis, and accordingly may focus on some kinds of information and not others. The implications for this are that, ideally, health care practitioners should first inquire about the concerns particular to each patient, thus enabling them to adjust the given information to the patient’s needs. Adequate patient education requires the right balance between meeting and responding to the patient’s wishes and the therapist’s plans for the treatment and targeted outcome. It is too late for the physiotherapist to introduce risks of manipulative treatment whilst cradling the patient’s head, assessing joint restriction and preparing to manipulate.

In a study examining the factors influencing the quality of informed consent prior to surgery, it was found that the optimal time for patients to receive pre-operation information cards is before admission, either when the patient is put on a waiting list or one week before treatment.

Assessing patients’ current knowledge and perceptions

Some patients are likely to receive, process and recall information relating to their surgery poorly: elderly people, patients with a low IQ, those with impaired cognitive functions and those with an

56 Braddock et al, n 18.
57 Rogers v Whitaker (1992) 175 CLR 479.
61 Wadey and Frank, n 60, at 125.
62 Sluijs, n 58.
external health locus of control. In relation to obtaining meaningful informed consent from older adults, personal characteristics that were associated with positive comprehension included positive mood, increased locus of control, high anxiety and a high level of education.

When given new information, people tend to select the information that is personally relevant for addition to their prior knowledge. If the information goes far beyond the education level of the patient, it is either dismissed or changed to fit the patient’s level of understanding. It is therefore important actively to discover the patient’s perceptions by listening carefully to the patient and asking specific questions about their clinical interests and anxieties.

This active process on the part of a surgeon was investigated in a study that examined the effect of pre-operative patient verbalisation of the risks and benefits of anterior cruciate ligament (ACL) reconstruction. Twelve patients who made up the control group received a standard surgical consultation outlining the proposed surgery and gaining informed consent. The eight patients in the experimental group were exposed to the same consultation, but were also required accurately to verbalise (using their own words) the associated risks and benefits before operation. One month after this consultation, the patients who had verbalised their understanding of the risks and benefits of surgery demonstrated a significantly greater understanding than those in the control group who were given the same information, but not required to verbalise their understanding.

A study of two different styles of communication in which parents were informed of a child’s developmental disabilities further highlights the relationship between physician assessment of understanding and subsequent patient comprehension. The first style, which Roter and Frankel define as “non-interactionalised”, involved the delivery of diagnostic information without respect to the point of view or perspective of the parent. It led to a series of strong rejections by the parents. The second style involved the doctor precedin the information with a question designed to assess the parents’ knowledge and perspective on the child’s problem. Having elicited their perspective, the information was framed using language the parents had used. This enabled better understanding and acceptance of the information. The conclusion was that, when giving information that is meaningful, it is important to first assess a patient’s current knowledge and perceptions. Keller and Carroll also suggest that listening to the language of the patient and adapting “your language system to meet theirs” facilitates meaningful exchange of information. Specifically regarding manipulation, patients may have very different understandings and perceptions possibly based on friends’ advice, the media and different health care advertisements.

The fact that perceptions of health practitioners and patients may differ markedly in relation to information given and received was the focus of a study by Gahimer and Domholdt. They stressed that reliance on patients or therapists to self-report on information exchange may not be reliable for research, and to presume that a patient has understood on the basis that information has been given may, in some instances, be completely false.

**Written information reinforces verbal communication**

Written information provided in conjunction with verbal information enhances comprehension. In relation to physiotherapists, an investigation of the mode of teaching exercises – comparing the use of brochures versus therapist teaching using verbal instruction – on the accuracy of performance of exercises and resultant change in impairment, reinforced the notion of combining written and verbal information. Exercises based only on

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64 Lavelle-Jones et al, n 63, at 889.
65 Sugarman et al, n 33, at 517.
67 Keller and Carroll, n 47, at 136.
68 Wadey and Frank, n 60, at 124.
69 Roter and Frankel, n 36.
70 Keller and Carroll, n 47, at 135.
73 N Friedrich, T Cermak and P Maderbacher, “The Effect of Brochure Use Versus Therapist Teaching on Patient’s...
written instructions were often not performed properly and therefore led to poorer outcomes, compared with exercises learned under verbal instruction and supervision from a physiotherapist. A related study demonstrated that verbal instruction alone facilitated low levels of compliance whereas the incorporation of written and illustrated exercise instructions was a more effective educational strategy to improve exercise compliance in the management of low back pain. Clearly, verbal instruction alone, or a brochure alone, is often inadequate. The combination apparently also produces greater understanding in the context of obtaining informed consent.

The APA-revised pre-manipulative protocol provides the following advice:

• Provision of information brochures is optional but allows the patient the opportunity to read about the proposed treatment at their own pace and in their own time and formulate any questions. They can be given to the patient to read in the waiting room prior to treatment.

• The physiotherapist must be prepared to provide information beyond what is written in the brochure, if the particular patient requests further information, or if in your opinion, there is further information that the patient would consider important if they knew of it.”

Based on past studies, individual physiotherapy practices/clinics should consider ways of ensuring that patients are given time to read available information, which obligates individual practitioners to reflect on how best to provide this opportunity. There is a need to balance the value of provide written and oral information because patients appear to forget about half the information they receive. The more information they receive, the more they forget. To avoid information overload, therapists should carefully select information essential to patients’ particular demands.

Physiotherapy education in The Netherlands places equal emphasis on patient education and treatment plans. Students are taught to devise an educational program, then enter it on the patient’s record in the same way as a treatment plan.

An information or education plan for individual patients would go some way towards fulfilling the legal duty to provide relevant information on a systematic basis. When a patient presents for physiotherapy, the appropriateness of manipulation as a form of treatment would then become automatic during physical assessment of the patient and, indeed, during the subjective questioning of the patient. Moreover, physiotherapists should be able consciously to interrupt the flow of treatment to explain, or further explain, risks at a time where the context is optimum.

Physiotherapists need to be actively prepared for providing information to patients in a variety of ways. Importantly, it will generally be too late and untimely to provide the information in the form of brochures part way through the consultation. If timing is poor, patients may be unduly pressured in their decision-making. The therapist is likewise under economic and timing pressures to move forward through the consultation, resulting in a most unsatisfactory coincidence of considerations.

Written communication

When considering health-based written information, there have been many studies about readability of information and relatively few studies looking at whether health professionals actually get their message across. The main themes to emerge from past studies are:

1. the effectiveness of written information depends on readability, legibility and learnability of the material;

2. written information reinforces verbal information;

3. written information should be part of a planned education program.

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73 Sluijs, n 58.
74 Foltz and Sullivan, n 72.
75 Suijs, n 58; Keller and Carroll, n 47; Ong et al, n 23; Arthur, n 34.
76 Sluijs, n 58, at 507.
77 Arthur, n 34, at 1085.
79 Sluijs, n 58; Sugarman et al, n 33.
Readability

Readability is linked to patient comprehension of information materials. The challenge is to develop written materials with a good fit between the material and reader. Most tests for readability are based on systems of scoring by counting sentences and words. Albert and Chadwick used the “Gunning fog test" to assess doctors’ general practice information leaflets and found them satisfactory at 11.6. However, 16 of the 79 leaflets had a reading score of 14 and over, which equates with papers in the British Medical Journal. Meade and Smith examined several readability formulas and concluded that the score may give a false sense of validity. The reading level estimate of a written passage determined by a readability formula is only one element that needs to be considered. Other factors include human factors, such as reader educational level, socioeconomic position, cultural and experiential factors and the visual attractiveness of the material. Other studies regarding education of cancer patients disclosed that patients’ stated educational level is not equivalent to their reading and comprehension level.

Another study compared the readability of patient consent forms for research protocols with that of daily newspapers. The authors found that of the 50 consent forms analysed, the majority were more difficult to read than newspaper editorials. Poor readability was caused by the use of long paragraphs and long sentences, not the excessive use of long words. Based on the findings from the above studies, practical ways of producing more readable leaflets include:

- the writing should be personal; and
- messages to patients should be tailored to the patients’ cultural and experiential background.

Legibility

Legibility refers to how easily letters and words can be recognised. Techniques such as balancing white and black space, selection of readable print size, type and format all affect legibility. Simplification of information by providing it in the form of a storybook, lower reading level and using larger typeface may improve legibility and increase comprehension.

Learnability

The concept of learnability is especially noteworthy when educational messages need to incorporate cultural or experiential history in the patient target group. The legal concept of informed consent stresses the importance of tailoring the information to be provided to patients. Not all patients can be given the same style or format of information. The conceptual background of the reader, the concept load in the text and the layout of the concepts in the written material all contribute to learnability. When developing written materials, assessing patients’ current knowledge of the topic, determining their perception of their need for information and identifying learning barriers or motivational factors are all important tools to enhance learnability.

Video, computer and other communication methods

For certain health care messages, reducing the amount of reading material in favour of other information sources may be more appropriate. An obvious medium with an attraction for physiotherapists where patients may be in a waiting room or gym area, is the visual presentation of materials whether on video, on a poster or in an interactive or other computer setting.

Videotaped instruction has been demonstrated to be as effective as other instructional methods, and...
often more effective than printed materials alone.\(^97\) One investigation compared the effectiveness of printed or videotaped information as the medium used to enhance patient knowledge of colon cancer.\(^98\) Whilst the authors found no significant differences between printed materials, written at low reading levels (Grades 5 to 6), and videotape material in the enhancement of patient knowledge, they believed both mediums were equally effective because they were specifically tailored to the target group. Special attention was given to developing content that reflected ethnic diversity; that was organised in a clear manner; that was written or narrated in conversation style; and which used short words and sentences.

More recently asthma patients expressed a preference for watching video over written information.\(^99\) In one study of asthma education,\(^100\) whilst patients expressed a preference for booklets in asthma education, they learnt more from audio cassette.

**Current physiotherapy practice**

There have been few studies that have specifically investigated the current practice of physiotherapists relating to informed consent. A 1991 review of the original APA pre-manipulative testing protocol by questionnaire found a high level of compliance with the physical screening procedures advocated by the protocol.\(^101\) Less compliance was found in the area of physiotherapists obtaining informed consent, specifically by use of the protocol-suggested wording. Many of those responding felt that the requirement of informed consent on the part of the patient would mean fewer patients would agree to manipulation as a form of treatment, and this valuable method of treatment would therefore be used less frequently.

Concerning physicians, the explanation of reluctance to participate in achieving ideal consent included lack of time and lack of recognition of the need for shared decision-making.\(^102\)

In general, physiotherapists value the role of patient education in the normal course of treatment.\(^103\) The amount of patient education is unplanned and usually occurs early in a series of treatments.\(^104\) However, regarding specific provision of information with a view to obtaining informed consent, there appears to be some reluctance, because providing such information is cumbersome in clinical practice,\(^105\) and may dissuade patients from accepting the treatments.\(^106\)

**Summary**

Figure 1 provides a summary of the styles, methods and mediums of communication that should be considered when sharing information in a clinical encounter. An ideal consent is one in which patients are given sufficient information concerning the nature of their condition, the nature of the proposed treatment, possible alternative treatments and chances of success or failure of proposed and alternative treatments.\(^107\) Ideal consent incorporates the legal principle of a right to self-determination. Patients have different desires for information and they frequently have questions that they will not ask or that will not occur to them until after they have left the health care practitioner’s rooms.\(^108\) This in itself makes the process of informing patients a complicated one in which education does not take place until patients are able to utilise the information in an effective manner.\(^109\)

Keller and Carroll\(^110\) propose a model of patient-physician communication which is equally

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\(^101\) Keller and Carroll, n 47, at 138.

\(^102\) Braddock et al, n 18.


\(^104\) Sluijs, n 58, at 507.

\(^105\) Magary et al, n 28.

\(^106\) Grant and Trott, n 101.

\(^107\) Rezas and Forrester, n 16.

\(^108\) Keller and Carroll, n 47.

\(^109\) Keller and Carroll, n 47, at 139.

\(^110\) Keller and Carroll, n 47, at 138.
applicable to physiotherapists. Their specific strategy is that physicians should assume patients want to know the answers to the following questions:

- What are you doing to me (examination, tests)?
- Why are you doing this rather than something else (diagnostic or treatment options)?
- Will it hurt me or harm me, for how long, and how much (diagnostic and treatment)?
- When and how will you know what these tests mean?
- When and how will I know what these tests mean?

The assumption that patients want (and are entitled to) answers to such questions also reflects the requirements of legal principles of informed consent.

Health care practitioners need to expand their views of informed consent. That is, so as in order to recognise that many clinical decisions deserve thoughtful discussion and shared decision-making. This expansion in thinking also needs to apply to methods of obtaining ideal consent, where all elements of shared decision-making, appropriate methods and style of communication can be utilised. The informed consent process should not be designed to deliver a “one-size fits all” disclosure, but should be custom-tailored to meet the differing informational needs of patients.

For physiotherapists, future research needs to focus on questions investigating the relationship between the content of information and the ability of patients to remember and understand this information. Other questions that need answering with respect to legal and ethical obligations of informed consent include:

- What is the right amount of information to give?
- What is the correct sequence of advice?
- What is the optimal medium of provision of such information or advice?
- Does a planned systematic educational program make it easier for physiotherapists to distribute information?

The process of obtaining informed consent such that a meaningful exchange between health practitioner and patient takes place depends on many variables. This review has discussed some of these variables in light of legal requirements and highlighted the most effective methods of obtaining ideal informed consent.

Physiotherapists need an understanding of current legal concepts of informed consent. They then need to be able to steer their communication strategies in the same direction. Informed consent in clinical practice should not be influenced by a narrow interpretation of legal obligations of full disclosure. Thoughtful and reflective communication strategies, where the basic premise is that the patient has a legal right to know about treatment benefits, risks and alternatives, will help to solve the complexity of obtaining ideal informed consent in a busy clinical practice.
Figure 1. Summary of Elements of Effective Information Exchange

Table 1. Summary of Elements of Effective Information Exchange

<table>
<thead>
<tr>
<th>Effective Information Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General context</strong></td>
</tr>
<tr>
<td>- Consider patient's background, culture, age, IQ, education, preferred learning style and mood</td>
</tr>
<tr>
<td>- Be personal</td>
</tr>
<tr>
<td><strong>Photos / diagrams / models…</strong></td>
</tr>
<tr>
<td>- Use to embellish verbal and written communication</td>
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<tr>
<td><strong>Videotape / audiotape…</strong></td>
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<tr>
<td>- May be more effective / interesting than verbal or written communication</td>
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<tr>
<td><strong>Computer / internet…</strong></td>
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<tr>
<td>- As for video- and audio-tape</td>
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<tr>
<td><strong>Audiovisual</strong></td>
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<tr>
<td>- Use open questions</td>
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<tr>
<td>- Make information accessible to each patient</td>
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<tr>
<td>- All patient tone in congruent face expressions</td>
</tr>
<tr>
<td><strong>Timing…</strong></td>
</tr>
<tr>
<td>- First assess patient's readiness to receive information</td>
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<tr>
<td>- Exchange information before beginning treatments</td>
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<tr>
<td><strong>Verbal</strong></td>
</tr>
<tr>
<td>- Allow patient time to complete their statements</td>
</tr>
<tr>
<td>- Take patients' views / concerns seriously</td>
</tr>
<tr>
<td><strong>Patient understanding…</strong></td>
</tr>
<tr>
<td>- Consider patient's age, IQ, education and mood</td>
</tr>
<tr>
<td>- Elicit and evaluate verbal feedback from patient</td>
</tr>
<tr>
<td><strong>Verbal</strong></td>
</tr>
<tr>
<td>- Use large typeface, but not all-caps</td>
</tr>
<tr>
<td>- Use short sentences and short words</td>
</tr>
<tr>
<td>- Avoid unnecessary words</td>
</tr>
<tr>
<td>- Use narrative text</td>
</tr>
<tr>
<td><strong>Legibility…</strong></td>
</tr>
<tr>
<td>- Use simple, familiar vocabulary</td>
</tr>
<tr>
<td>- Use simple, familiar, unrelated phrases</td>
</tr>
<tr>
<td><strong>Written</strong></td>
</tr>
<tr>
<td>- Use simple formatting</td>
</tr>
<tr>
<td>- Use simple, balanced, uncluttered layout</td>
</tr>
<tr>
<td><strong>Learnability…</strong></td>
</tr>
<tr>
<td>- See 'General context'</td>
</tr>
<tr>
<td>- Use concepts patient will understand</td>
</tr>
<tr>
<td><strong>Written information reinforces verbal information</strong></td>
</tr>
</tbody>
</table>

Legend: Use / emphasize / focus on (patient's needs / concerns / values / preferences / culture / education / background / learning style)
Discussion

Respecting patient autonomy and obtaining their informed consent: ethical theory—missing in action

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Abstract

The legal and ethical requirement to obtain a patient’s informed or valid consent to treatment is founded on the philosophical theory of patient autonomy. This paper discusses this theory and its application to informed consent in the biomedical literature. The paper then reviews physiotherapy ethical knowledge by examining how the physiotherapy ethical literature has discussed the philosophical theory of autonomy and related it to the obligation to obtain a patient’s consent to treatment. The review concludes that the physiotherapy-based discussion of the ethical theory of autonomy as it relates to the duty to obtain valid consent emphasises prescriptive compliance with duty and is comparatively undertheorised. A hypothetical case study is used to highlight the difference between an ethical approach to obtaining consent that explicitly uses the theory of autonomy and an approach that relies on compliance with duties.

Keywords: Informed consent; Valid consent; Autonomy; Philosophical theory

Introduction

Informed or valid consent has a history in law, ethical theory, and clinical and research practice [1–3]. Its defining elements in clinical practice are disclosure of information by the clinician, comprehension and consent from the patient, and preconditions of voluntariness and patient competence. The philosophical theory that underpins informed consent is the idea of autonomy, defined as self-governance or self-rule [3], a capacity of people to reflect and choose [4], and freedom to express individual aspirations and preferences [5]. Understanding the meaning of autonomy as the ethical basis of the process of obtaining a patient’s consent allows a more flexible approach to individual patient needs and different clinical contexts [4,5]. In the biomedical literature (written for the medical profession), several models of practice have been developed that aim to link the philosophical theory of autonomy explicitly to the clinical practice of obtaining informed consent [6–11].

In the physiotherapy literature, the recognition of and attention to professional accountability [12–15] and call for greater understanding of ethical issues [13–21] has involved a similar recognition of the need to obtain patients’ informed or valid consent in clinical practice [22–29]. In 2002, Swisher [17] conducted a retrospective review of the examination of ethics in the physiotherapy literature based on the period 1970–2000. The review identified that during that period, the profession’s ethical approach was predominantly based on a philosophical principles perspective. That is, much of the ethics literature was prescriptive in its approach and was concerned with prescribing what people ought to do and how they ought to conduct themselves from the basis of relevant ethical principles. In their recent study of ethical reasoning and its relationship to clinical reasoning, Edwards et al. [30] acknowledged that although they did not address philosophical ethical theories, an understanding of ethical theories is important for the ethical reasoner to draw upon in the same way that a background knowledge of anatomy and physiology is important in clinical practice.

This paper aims to build on these recent reviews of ethical knowledge and reasoning in the physiotherapy literature, focusing in more depth on the philosophical principle of autonomy and how that principle has been linked to the practical ethical obligation to obtain patients’ informed consent. The assumption underlying this analysis of the physiotherapy
literature is that compliance with ethical duty without concomitant understanding of underlying ethical theory will lead to a mechanistic and narrow approach to the clinical communication required for obtaining a patient’s informed consent to treatment [31,32]. The paper also employs a hypothetical case study to highlight and demonstrate differences between an approach to obtaining consent based on explicit reflection and analysis of ethical theory, and an approach that relies on compliance with ethical and legal duties stipulated as necessary for obtaining a valid or informed consent.

The review used the same search strategy as Swisher [17] (peer-reviewed journal articles cited in MEDLINE or Cumulative Index to Nursing and Allied Health Literature (CINAHL) 1970–July 2000) to search for papers that have discussed autonomy and/or informed consent, and extended the search to April 2005.

**Philosophical theories of autonomy**

Deontological and utilitarian theories and positions taken, respectively, by the philosophers Kant [33] and Mill [34] provide the foundational moral arguments for why it is important to respect a person’s autonomy. Kant’s [33] theory of respect for autonomy is grounded in what it means to be a rational agent and to do what is right. The ideal of autonomy from a Kantian perspective refers to the inherent value of the dignity of the person, including their unique ability to be self-legislating or autonomous. In a clinical setting, the idea of autonomy according to a Kantian account requires that the practitioner has a well-grounded knowledge and sense of what guides his or her own decision making. That is so because it is the idea of self-knowledge and self-respect that precedes and determines expectations of others. This requirement of self-recognition as a rational agent and self-reflection is independent of the values and outcomes that may also influence the exchange of communication [35]. From this perspective, respecting the autonomy of another person, or patient in a clinical context, requires respecting the person as an equal, in particular, acknowledging an equality in the ability to self-reflect and make choices.

According to Mill [34], actions and choices are to be judged as ‘right’ or ‘wrong’ in terms of their promotion of happiness [34,36]. This means that what is important to an individual’s autonomy is not so much whether the person acts from the basis of personal reason (as Kant advocated), but that their actions represent a freedom to choose what is personally fulfilling or what would maximise their own happiness. Following Kant and Mill, other philosophical accounts of autonomy have been developed that utilise aspects of both deontological and utilitarian theories in providing an account of the essence of autonomy. For example, Dworkin [4] defines autonomy as a capacity of a person and part of their character. Using Dworkin’s account of autonomy, obtaining the consent of the patient without knowing about the person, their views, identity and character would contravene the notion of respect for the person’s autonomy. The underlying assumption is that the person’s beliefs, values and identity are embodied within their physical sense of self. Applying Dworkin’s view, there should be both recognition and active encouragement of the patient’s views and individual character. Gaining the patient’s consent to a treatment based on this understanding of what autonomy means must therefore encompass at least some curiosity and at best a reasonable enquiry as to the internal motivation and beliefs of the patient.

In Young’s [5] view of autonomy, both capacity to reason and freedom to choose are construed as positive forces that direct one’s own life. The implication for health practitioners who are required to respect the autonomy of their patients is that the focus should be to enhance a patient’s reasoning and ability to choose, and not just an obligation to respect a patient’s freedom to choose. Adopting Young’s approach, to proceed in this manner is to harness the patients’ own positive forces in the context of the clinical encounter.

The main message inherent in these philosophical views of why autonomy is important and what it consists of is not so much a prescription of what information to impart or what obligatory action to take. Instead, they provide a way to think about the meaning of autonomy and suggestions as to what sort of attitude to adopt, both of which provide a more flexible guide to ethical reasoning in a range of circumstances involving informed consent.

**Bio-ethical literature: current understandings of the relationship between autonomy and informed consent**

Several authors, writing for medical practitioners, have developed models of practice that explicitly link the ethical theory of autonomy and the clinical practice of obtaining a patient’s informed consent to treatment [6–11]. Some of the models focus on specific actions oriented to ensuring compliance with professional standards and the law [7,9]. Others [6,10–11], most notably Katz [8], focus on the need to reflect and think about the meaning of patient autonomy as a way of informing shared decision making and attitudes within the clinical relationship.

Brody [10, p. 97] developed the ‘transparency model’ as an approach to ensure that adequate information has been disclosed to a patient in a medical encounter. In his view, adequate information has been given when ‘a reasonably informed patient is allowed to participate in the medical decision to the extent that the patient wishes’. Reasonably informed consists of two features. First, disclosure should not only contain the treatment decision, but the basis for the decision; ‘disclosure is adequate when the physician’s basic thinking has been rendered transparent to the patient’. Second, there should be space for the patient to ask questions about such disclosure. Although Brody’s model provides a positive obligation on practitioners to reveal more informa-
viously by Dworkin [4] and Young [5]. If both the patient’s reflection of a person’s capacity and freedom discussed pre-capacity for exercising those rights. Both components are a tion of rights of self-determination to human psychological processes ought to occur, to what choices should be actually understood in the physiotherapy literature reveals two categories of responses. The more common response has been to stipulate that obtaining patients’ informed consent is an ethical duty recognised as an implicit aspect of health care, and a legal duty with which compliance is expected [15,22,23,25,26,29,37–41]. The second, less common response is a discussion of the meaning of the underlying ethical principle of autonomy as a way of defining the practical action of obtaining informed consent [27,42–46]. The following statements are reflective of the more common response in the literature [39]:

- patients must be included in the decision-making process;
- physiotherapists must be knowledgeable about benefits and risks of treatment alternatives; and
- patients must be allowed to refuse treatment that they do not desire.

Professional guidelines and codes of ethics are good examples of this type of response as they seek to stipulate the duty to obtain informed consent as an ethical and legal requirement of practice. For example, Standard 2 of the Core Standards of Physiotherapy Practice [47] focuses on the element of information disclosure by stipulating that in order to obtain the valid consent of patients, they must be informed ‘of all potential and significant risks, benefits and likely outcomes of treatment’. The basis of this recommendation is a legal one, known as the Bolam Standard [48], more recently refined in England in the Bolitho case [49]. This legally defined professional standard requires that practitioners must demonstrate that the information given to a patient has a logical basis and represents a body of professional opinion.

In 1988, the Australian Physiotherapy Association [50] responded to the ethical and legal requirement of informed consent by formulating a practice protocol or clinical standard for premanipulative testing of the cervical spine. The aim was to ensure physiotherapists’ legal compliance with obtaining patients’ informed consent prior to cervical manipulation. A 1991 review [51] of this protocol by questionnaire found a high level of compliance with the physical screening procedures prior to the treatment, and less compliance with the process of obtaining informed consent, specifically by use of the protocol-suggested wording. Many respondents felt that the requirement of informed consent on the part of the patient would mean that fewer patients would agree to manipulation as a form of treatment, and this valuable method of treatment becomes a form of treatment, and this valuable method of treatment
would therefore be used less frequently. Further review of the protocol [52] and research examining practitioner compliance demonstrated that whilst respondents (practitioners with postgraduate qualifications in manipulative therapy) perceived the legal necessity, many acknowledged a failure to comply with the requirement of obtaining informed consent measured against the guidelines.

The guidelines and discussion by physiotherapy writers [42,53–55] provide direction for physiotherapists to make clinical judgments and decisions. However, they do not assist or provide guidance in negotiating decisions that incorporate the patient’s wishes or understanding in relation to the treatment. They do not specifically link the action of informed consent to the philosophical theory of autonomy. The responses to the surveys provide some evidence that if informed consent is prescribed as a specific duty, without accompanying education or discussion of the underlying meaning of respecting patient autonomy, there is a danger that the obligation will prove to be too rigid a requirement to practically apply.

The second, less common response in the physiotherapy literature is a discussion of the meaning of the underlying ethical principle of autonomy as a way of defining the practical action of obtaining informed consent [27,42–46]. The seminal article is by Coy [43], where the author aimed to demonstrate the value of understanding the moral meaning of autonomy as a basis of action for informed consent. Coy refers to the following description of the principle of autonomy [56]: ‘... the view that individuals are entitled to be and do as they see fit, so long as they do not violate the comparable rights of others. No person is to be merely the instrument of another person’s plans; no person is to be treated in a manner that is blind to the plans, desires, and values that are the fabric of his or her life and identity. Roughly speaking, we believe that it is obligatory to leave people alone, unless we have powerful reasons for not doing so.’

This definition incorporates the conceptual ethical notions of respecting a person’s capacities, values and desires, in addition to respecting their right or freedom to autonomy or choice [4,5]. Similarly, Sim [27] refers to a definition of autonomy that emphasises a person’s capacities to think and act on the basis of such thought, and not just on the basis of freedom to act.

Coy [43] maintains that when this broader meaning of autonomy is applied as an underlying reason for obtaining informed consent, it expands the situations in which informed consent becomes an important issue. Informed consent from this moral basis is as important for routine treatments as it is for treatments that involve potentially harmful consequences [43].

Coy’s discussion is similar to that of Katz [8] insofar as the focus on the ethical theory of autonomy not only broadens the scope of informed consent, but also moves away from the idea of a physiotherapist performing a set list of actions, to thinking about and relating to each patient as a person. This notion of autonomy as a basis of informed consent also provides more flexibility and scope for a therapist to independently adapt and respond to a patient’s individual needs.

The following hypothetical case scenario provides a theoretical comparison of, on the one hand, how a therapist might comply with the elements of a valid or informed consent by disclosing information that allows a patient the freedom to make a choice. On the other hand, how the same therapist, armed with an understanding of the ethical theory of autonomy, provides broader and arguably more meaningful guidance to a patient, offering a greater degree of autonomy incorporating both freedom of and capacity for autonomous decision making.

A case scenario: complying with information disclosure requirements

Mary is a 35-year-old secretary with recurring episodes of low back pain over 6 years. She has never been an active person, and she is not skilled at sport. She has uncomfortable memories of being teased as a teenager for her lack of co-ordination and sporting ability. Mary’s low back pain is becoming more constant, and she has never been to a physiotherapist before.

Sonia graduated 5 years ago and works in a private practice physiotherapy setting. The idea of patients contributing to their own care and being actively involved in managing their own problems appeals to Sonia. Sonia has always valued fitness and self-motivation. She is a firm believer in the power of self-discipline. Sonia recently attended a course dealing with abdominal muscle stabilisation exercises.

Within the treatment, Sonia asks Mary questions related to the nature of the low back pain, including the duration, time of occurrence, severity, and aggravating and easing factors. Sonia assesses Mary’s active movements and decides that Mary’s problem is caused by too many hours of poor posture sitting at the computer. Sonia explains what she thinks Mary’s problem is and how she intends to treat it.

Sonia has decided that Mary is a candidate for treatment using abdominal muscle stabilisation exercises. Prior to attending the weekend course, Sonia may have given Mary a different treatment. She may have given Mary manual therapy, consisting of mobilisation, massage and some local heat therapy. Sonia explains to Mary the long-term benefits of performing the particular exercises and how they will gradually reduce Mary’s pain. She demonstrates the exercises and gives Mary an exercise sheet. Mary arranges an appointment the following week.

Specific compliance with the elements of informed consent

To meet disclosure requirements of informed consent, Sonia needs to provide information to Mary about the benefits and risks of abdominal muscle exercises. In Sonia’s
view; there are only benefits and very few physical risks of this treatment. Sonia notes that Mary is completely competent to understand the treatment and its consequences. She takes notice of Mary’s expressions and willingness to proceed, interpreting these as her consent to the treatment. As the treatment involves few risks, Sonia does not believe that a more formal protocol or process should be followed. Sonia is satisfied that she has discharged her legal and ethical duty to obtain informed consent.

Obtaining valid consent using philosophical understandings of autonomy

Using the philosophical meaning of autonomy as the underlying ethical framework, Sonia starts from a position of respecting and providing opportunities for Mary to exercise choice. Sonia would also be aware of potential barriers that may restrict Mary’s ability to make meaningful choices. Sonia would ask questions because respect for patients’ autonomy, rights and capacities would be seen as valuable commodities in the treatment encounters as achieving a measurable treatment effect or outcome.

As a physiotherapist, Sonia would not simply seek out signs and symptoms that accord with her ideas of treatment and intervention. Sonia would be willing to explore and take into account Mary’s reasonable and non-reasonable decisions, values and judgments.

Sonia would need to reflect on the values and source of those values that motivate her preference for exercise therapy. For example, she could relate to Mary that the basis of the physiotherapy intervention of exercise therapy was scientific research evidence, an interest in long-term results and a belief in the importance of self-management by patients. Sonia may also relate her personal preference for exercises due to her emphasis on self-discipline for solving problems.

Sonia would then demonstrate an equal interest in Mary’s values and preferences. Enquiries would be made, such as ‘How do you feel about following a treatment with a regime of exercises and changes to your posture at work? Tell me about your expectations of this treatment. Do you share my view of self-discipline and the value of exercise or do you have another view?’ So long as the questions are asked in the spirit of discovery and equality, the exact wording is unimportant.

Sonia would have a particular view of her relationship with Mary. It would not be a view based on the traditional premise that Mary should trust Sonia’s judgment because she has the most current evidence-based treatment to offer. Instead, Sonia would have a more flexible and patient centred view where multiple options are presented and the patient/therapist encounter does not begin and end from a ‘compliance with duty perspective’. Rather, it encompasses a respectful curiosity on the part of the therapist as to both the capacities and processes of decision making of the patient and of the patient’s views and individual character. Such an approach also encourages the physiotherapist to actively recognize the distinction between clinical knowledge, treatment purposes and practice environment on the one hand, and the influences of the therapist’s own values and capacities to think, reason and reflect on the other. This recognition, in turn, encourages the therapist to recognize the distinction between the patient as a person with an illness or dysfunction and their autonomous capacities to make their own choices and decisions. Informed consent to treatment in this context demands a process that considers the autonomous capacities of the patient in the particular clinical circumstances.

Summary and conclusion

This paper has reviewed the incidence and manner in which physiotherapy literature has considered informed consent. The physiotherapy literature was reviewed against a background of the broader context of the meaning of the underlying ethical theory of autonomy and its interpretation in models of practice of informed consent developed for medical practitioners. An important finding of this review is that the conception of autonomy that supports the discussion of informed or valid consent in the physiotherapy literature is comparatively narrow and undertheorised.

Philosophical theories of autonomy discussed in this paper widen the meaning of autonomy to encompass both rights and capacities of a patient to make autonomous choices. Models of practice developed for medical practitioners demonstrate that deeper understandings of these concepts of autonomy facilitate more flexible responses to patient choice. The review of the physiotherapy literature demonstrates that the prevalent focus has been to define ethical obligations from a compliance perspective, rather than to define the underlying ethical theory from an understanding perspective. The hypothetical case study highlights how the procedure of obtaining a patient’s valid consent to treatment may be enhanced and applied more flexibly by an understanding of the ethical theory of autonomy.

Becoming clearer about the sources of principles and judgments that direct ethical action has both theoretical and practical importance [4]. At a practical level, meeting a person’s individual needs for information and choice based on a deeper understanding of their autonomy means that rules and proce-
Key messages

- The legal and ethical requirement to obtain a patient’s informed or valid consent to treatment is founded on the philosophical theory of patient autonomy.
- Models of practice developed for medical practitioners demonstrate that understanding the underlying ethical theory of autonomy facilitates more adaptive responses to patient rights and capacities for autonomous choice and contribution within the clinical encounter.
- The physiotherapy literature has focused more on defining ethical obligations and less on understanding the underlying ethical theory.
- Greater attention to theoretical assumptions and philosophical meanings of the concept of autonomy may enhance the practical implementation of the obligation to obtain patients’ valid consent to all physiotherapy treatments.

References


[49] Bolitho v City and Hackney Health Authority. In: [1997] 4 All ER; 771.


