Autonomy and the Future of Physiotherapy

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ABSTRACT

While the roots physiotherapy are surely in prehistory with touch, massage, manipulation, heat and ice, the first organizations that could truly be referred to as physiotherapy arose in 18th century Scandinavia. Then it was essentially masculine and independent of medicine and thus autonomous. Subsequent events in Scandinavia and elsewhere led to medicine dominating physiotherapy where it existed. Medicine then dictated the educational content, granted licensure, and controlled access to patients with a prescriptive relationship. Referred to, in modern times, as "allied health professions", physiotherapy along with other so labelled disciplines were often and some still remain subservient to the medical establishment.

Today however, in most western nations, the emerging profession of physiotherapy finds itself at varying degrees of autonomy and preparedness for professional independence. With the advent of the clinical doctorate in the USA the profession needs to reflect on preparedness to be a profession whose practitioners hold a clinical doctorate, it's the scope of practice, evidence-based research and action needed to address any shortcomings.

Our profession is at a crossroads. Does it shuffle along meeting expectations and accountability as defined by others, or does it take the step of an in-depth assessment of a future role; a role designed that would assure that we become the profession of choice for all citizens when it comes to the restoration, maintenance and enhancement of the physical functioning? In taking such a step we must prepare for resistance and must be prepared to self promote our proven abilities. This paper will advocate that we take such a course for it is in the best interest of the client/patient. **Paris SV (2008): Autonomy and the Future of Physiotherapy. New Zealand Journal of Physiotherapy 36(2): 67-75.**

INTRODUCTION

Thank you It's certainly an honor to be invited to be a keynoter, It is one of special significance to me to be speaking to you here in Dunedin, the city of my birth and education which led to my becoming a physiotherapist – a decision I have never regretted.

Many moons ago when I agreed to give this address, it seemed that to speak on 'autonomy and the future of physiotherapy' should be a natural given my years of working for autonomy and my international involvement in practice, teaching, consulting and in holding office in professional organizations.

But then I began to question my ability to speak on this here in New Zealand (NZ) for while I am *one of you* I am at the same time *not one of you*.Thus I became concerned that my words on the future of physiotherapy, especially some critical remarks, might seem like an outsider coming in and perhaps giving unwelcome advice. I trust this will not be the case - but know at least that I am sensitive to it.

It has been said that "those who cannot remember the past are condemned to repeat it" (Santayana 1905). Therefore I shall begin with some physiotherapy history here in NZ and then abroad in order to see just how far some nations have come and others have not, and how much we have gained in autonomy and thus responsibility. This will set the stage for what I think is desperately needed at this time and that is once again a thorough practice analysis so that we can better make many of the decisions for our future. In the process I will cover aspects of practice, education, research and marketing all in order to better define who we are and who I consider we should be in order to act in the best interests of the client/patient.

HISTORY

I have been a physiotherapist for exactly 50 years. My father before me was the first male graduate of the school here in Dunedin – then I believe called the School of Massage and Medical Electricity.

My father was what I would now call autonomous practitioner in that he received referrals, rarely a prescription. His doctors knew him well and he knew his limitations. Thus his relationship with physicians were ones built on trust and mutual respect.

At the hospital clinics here in Dunedin it was a little different. While physicians on the whole may have known little of physiotherapy, they saw it as their responsibility to prescribe it and were so assisted by one of their own creations, namely specialists in physical medicine.

When I was a student the contrast between how my father practised and how most of the staff practised was troubling. It occurred to me that the only way I wished to practise was in the manner of my father. It seemed to me, however, that our lack of an academic degree, and graduating instead with a diploma and with no areas of recognized

specialization as was present in medicine and surgery – we had a long way to go to become a full profession with the autonomy that should accompany such a status.

So what is autonomy ?

Autonomous is defined by the Physiotherapy Board of NZ as "to be able to work independently of others appropriate to their education." (Physiotherapy Board of New Zealand 1999) This definition is quite unique and I would like to know where it came from. By contrast Dorland's Medical Dictionary defines autonomy as "the state of functioning independently, without extraneous influence." (Dorland's 1994).

During my studies as a student, I met with other leading therapists throughout the country including, Johnny Meney of Hamilton, the impassioned Len Ring of Auckland and Keith Ritson of Wellington. I noted that they on an individual basis had reached the same degree of autonomy as had my father – They were respected for their judgment; doctors sent patients to their practice and left it open for them to decide what treatment was in the patients' best interests. But they were exceptions and there were few able to practise with that degree of independence.

It was also apparent that as a profession we needed to advance clinical specialization. Only if we offered specialized skills akin to those in medicine and surgery, would we be able to bring the best of care to patients. Clearly we need generalists as does medicine, but we also need specialists. In the 1950s and 60s there was no means for identifying and recognizing who if any had those advanced skills.

It thus seemed to me that to advance the profession we needed autonomy to construct a profession that would have a degree on entry, advanced degrees for faculty and a means of recognizing specialized skills for the practitioner.

While a student at the school I had a life-shaping experience when conducting a class for back pain patients. One man had difficulty in getting one leg over the other while lying on his back. I simply flexed up his knee and gave him a little shove. Although the gym was busy with several classes going on at that time, it seemed there was no other noise to be heard when, from his back on the resonating wooden floor, there was a loud 'crack' for all to hear.

I was immediately disciplined in front of my class and the class nearing the end of the session was dismissed. My patient limped away. It was a Friday. I worried all weekend. On Monday he did not show up to the class – but then some ten minutes later he swaggered in, shook my hand and thanked me for "fixing" his back.

The instructor was still not impressed but it was time to talk to my father. He shared with me his collection of Mennell and Cyriax volumes and said that if I wanted on graduation to study this work and bring it to physiotherapy he would financially support it. He then recounted the many times that patients with whom he had on occasion limited success might go to a chiropractor and receive the relief they sought. My future was now clear to me. I would specialize in the spine.

On graduation I was allowed to specialize in treating spines in the outpatient department. One such patient, whom I assisted with a self taught Cyriax manoeuvre, was Dr John Fulton, then Chairman of the Otago Hospital Board. He was suitably impressed and grateful. When he said "I don't know how to thank you", I suggested a way that he could thank me – in fact, several! You see I had just read a book by a 26 year old author with the title "My Early Life". The author was Winston Churchill (Churchill 1930).

In that book Churchill outlined a philosophy to which I subscribe. I pass on to you today, especially to the younger persons present, that there are people in positions of power and influence who wish to mentor and help along younger men and women – however they are rarely asked to do so, but will jump at the opportunity if so asked. To further paraphrase Churchill's message, he went on to say that before you ask make sure you are prepared to receive the favour and never, never let them down..

Dr Fulton obtained for me a grant from the Workers' Compensation Board that introduced me to the leading lights in my field in Europe – such as Drs James Cyriax and Alan Stoddard of England, Robert Maigne of France and physiotherapist Freddy Kaltenborn of Norway. The list in America included spine surgeon Dr Paul Harrington and the deans of some osteopathy and chiropractic schools. I was well on my way to specializing in the spine, not just in its treatment by manipulation but by all means, including the study of biomechanics.

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Those years were 1960 and 1961 and I was only 23 years of age. Those embossed and important letters of introduction sent on ahead to make study arrangements were essential to the opening of doors for my learning.

At that time to become a teacher of physiotherapy here in Dunedin, it was the practice to go to England and undertake an apprentice-like training. There you were taught to teach The curriculum in those days held few references, little evidence for practice and required few if any visits to a library and did not seem to promote specialization and expansion into developing fields.

During this period, 1960-61, I saw physiotherapy practised in a half dozen nations working for the most part under medical control and prescription with little chance for conducting a patient assessment and modifying the treatment accordingly. It became obvious that if therapists were not allowed to evaluate their patient and make treatment decisions – how could they ever specialize? The knowledge they would gain would place their understanding in advance of most of those who would make referrals. This of course did not concern osteopaths and chiropractors who had direct access. So I added direct access to my list of what we needed besides autonomy, professionalism, degrees, and specialization.

But I also saw that in Norway, clinicians of Kaltenborn stature, were as autonomous as was my father, whereas in England physiotherapists were mostly technicians, except perhaps at St Thomas' where Cyriax would proclaim that "my girls know what to do." I was never sure where that left me!

Some time later I would learn of an interesting history in Sweden where in the early 1800's there were actually two primary healthcare professions. One was medicine, which of course was in its infancy given the absence of antibiotics and other life-saving and life-extending pharmaceuticals available today, and the other profession was best described as remedial gymnastics and physiotherapy. This latter group was principally made up of the sons of noblemen and thus had great influence on society. These therapists, as I shall call them, were directly able challenge medicine of the day with their approach to fitness and health. However the physicians felt threatened and after a long and bitter struggle lasting many decades, the physicians prevailed and managed to open the schools of physiotherapy to high school graduates, mostly females. Soon the profession was demasculanized and lacking its connection to nobility came under the control of the medical profession. So there was a case of autonomy – autonomy lost (Ottosson 2007).

"I earnestly believe that we are on the brink of achieving greatness as a profession"

In 1963, after a two year absence which had included looking after our Olympic Team at Rome - a position I had attained by once again doing what Churchill advocated and simply asked for the opportunity of serving the team little realizing they would make me a full member and that I would march on in the opening ceremonies – I returned to New Zealand. - I now wished to specialize in the spine and to use my acquired skills in manual therapy including manipulation.

A condition of my scholarship from the NZ Worker's Compensation Board was that I to teach upon my return. But this presented a problem because, quite understandably, the teaching faculty at the school objected to my teaching since I had not taken the customary teacher training that they, the other faculty, had taken in England. Due to these concerns I was appointed by the Medical School to the Physiotherapy School to be the Lecturer in Spinal Treatments.

I am sure I was less than diplomatic in my reasoning as to why I thought such training in the UK was out of date, a vestige of colonialism; that our future in teaching lay in gaining advanced academic degrees from a University;, and that practicing clinicians should play a much larger role in the teaching at the school.

Unfortunately New Zealand would be one of the last Western countries to offer a degree to its graduates and to require advanced degrees and/or experience for faculty. It would not be until 25 years later in 1993 that New Zealand students would graduate with a bachelor's degree.

I have to suspect that part of the reason for the delay was that we, as a profession in New Zealand, were well satisfied with our position within the health sciences. We enjoyed a respected relationship with our medical colleagues and the community.

Additionally no doubt, we were torn between the profession being a clinical profession and it becoming an academic discipline. Even a cursory glance at the American system would show that when physical therapy education went from the hospital to the university there was a decrease in emphasis on, and proximity to clinical practice. There was even discussion that physical therapists should become the evaluators of the patient and that the physical therapist assistants should be the clinicians!

In an article I published *NZ Journal of Physiotherapy* in May 1972 (Paris 1972) I compared Boston University education with that offered by the then New Zealand School of Physiotherapy. One point of comparison was that the New Zealand school had more than three times the patient contact hours before graduation than did Boston University students.

Clinically, I was able to operate a back pain service at the Dunedin hospital and to have an active and successful private practice. But it was not easy to practise as a specialist physiotherapist in New Zealand in 1962 when many of those who spoke officially for medicine and therapy felt that only the doctor could make the diagnosis and decide on the treatment. I called what I did a "clarifying examination". I vehemently defended the right of therapists to perform joint manipulation so that patient would not have to leave the orthodox medical arena to go visit a chiropractor to receive manipulation when indicated.

General medical practitioners in Dunedin supported that view and my practice with my father flourished. I rightfully denied that what I was doing was chiropractic and argued most strongly that it was part of practice in England and Norway. However our Journal declined two articles from me on the subject of manipulation.

It was the *NZ Medical Journal* that published, in 1963, my first article following a presentation I gave on manipulation at their national conference (Paris 1963).

Alarmed, the Chiropractic Board of New Zealand sued me for practicing chiropractic. I sought legal assistance and it was not encouraging. A leading light on the Physiotherapy Board of NZ, namely Keith Ritson, advised my father that I was on my own. The Board could not support the practice of spinal manipulation and, even if they should choose to do so, they did not have the financial resources that would be needed.

I reasoned that the Society was no doubt in a similar position. How was I to defend the right of a physiotherapist to practice manipulation at a time when such practices were considered chiropractic even at our only school? No matter the history that Hippocrates performed manipulation and so did Drs Mennell and Cyriax, both of whom instructed therapists in the techniques, – I was on my own here in New Zealand. So I wrote the Chiropractic Board stating that I would leave New Zealand and that they should – and they did – drop their charges.

Now my agreeing to leave New Zealand must have seemed like a retreat – and it was. But I saw as a strategic retreat for I had already planned to go to the United States to gain a PhD in biomechanics. I planned to return, to hopefully be appointed once again by the medical school to the physiotherapy school, As a medical school faculty member, I would be in a better position to withstand chiropractic efforts and be able to defend our right to practice spinal manipulation. But alas it was not to be. My domestic situation required that I remain in America.

But before I left – therapists such as Joan Derbidge of Christchurch, arranged for me to give a seminar. Others, such as Gordon Oldham, Brian Mulligan and John Meney asked that I conduct a series of two week long courses in each of the major centers. This I did. Some 85 therapists attended – almost 10% of the then therapists in New Zealand.

Just two years after my departure, the interest by physiotherapy in manipulation had grown to the point that in 1968 a group formed the Manual Therapy Association. I was thrilled. Then, in 1972, another important event in our path to recognizing special interests and needs: the Private Practice Association was formed.

No doubt, with these two groups organized and focused, this enabled the Society to be ready when, in 1978, the Government formed the Committee of Inquiry into Chiropractic. The society over the objections of the NZ Medical Association, presented its own case to the inquiry and, as a result, many feel that this was when physiotherapy in New Zealand came of age (Scrymgeour 2000). By making its own independent submissions and using its own expert witnesses, physiotherapy proclaimed that it was a fully-fledged profession – it had exercised the basic tenant of autonomy – self responsibility and independence.

The situation in the United States with regard autonomy was not as good as in New Zealand. Here in New Zealand individual therapists and the profession have, as a whole, always been held in high regard and with respect by the medical profession. There has been little discord or efforts to control and limit our growth. This is very evident in talking to New Zealand physiotherapists and physicians. No doubt gaining university status has enhanced this attitude and the common pursuit of evidence-based practice. But it is something very precious and it did not exist, as a rule, in the United States in 1978.

For instance just last month in California, a bill that would have granted direct access to physical therapy, now a profession with qualifications at the doctoral level, was defeated in the state legislature. Why? It's simple. The group that led the charge to defeat the bill were orthopaedic surgeons who still today much prefer to hire their own physical therapists and refer to them such that they can reap any profit from their referral-for-profit activities. This practice is unfortunately widespread amongst an increasingly greedy American medical profession.

But I'm getting a little ahead of myself and would like to give a little history on progress, and the lack of it, in America. In the 1960's and 70's we were, in the United States, very much under the control of the medical profession. The medical profession accredited the schools and thus dictated the curriculum, and on graduation they controlled the registration process. We were considered technicians and expected to behave as such. The code of conduct actually said that when a doctor entered the room we were 'to stand and smile sweetly'. Incidentally, male therapists were a rarity. In all of Massachusetts I was one of only three male therapists.

"You have the opportunity here to show the rest of the physiotherapy world exactly how to prepare for the future"

On the faculty of Boston University and with a clinical position at Massachusetts General Hospital I soon established orthopaedic support and entered private practice. My practice eventually grew to 34 employees.

We changed the Practice Act in Massachusetts in a way that slipped by the awareness of most physical therapists and medical practitioners at the time. We simply added the phrase that "physical therapists would be responsible for the treatments they gave." Legal interpretation – we now had the responsibility to examine our patients and determine the most appropriate treatments. You would think the medical profession would

see this as a sneaky trick to break their control. Perhaps some did. Surprisingly however it was the physical therapists that objected the most. They did not, in 1971, want that increased degree of responsibility. Yet gaining responsibility is the first step to professional autonomy.

We had some additional success with advancing clinical specialization. While the American Physical Therapy Association (APTA) did not wish specialty clinical interests groups within its umbrella, our 942 member manual therapy academy forced a change and won for us an Orthopaedic Section. This overnight became the largest special interest group within theAPTA.

I then moved to Atlanta Georgia and while on the faculty of Emory University made a big push to establish an advanced specialty master's degree for graduate therapists. Therapists were entering the profession with a bachelor's degree but there was little to no opportunity for those wishing to be faculty to gain a degree in an area of specialization – other than education. I thought it essential that the profession had qualified faculty with identifiable advanced clinical competencies. This was not the first time I had made such a proposal. The first was in Boston while at Boston University, and there it was the Medical Advisory Board that said specialization was not needed in physical therapy. At Emory University it was the Dean of Allied Health who rejected the proposal. The plan was denied without any opportunity for me to appear before them and argue the case. More discouraging was the fact that the chief therapist at Emory University asked that I not pursue it further, as "it might upset things." With such a request we were neither being treated, nor were we asking to be treated, as professional colleagues.

"I am a firm believer in autonomy and have spent much of my career striving to achieve it for myself, for my profession and for my educational institution."

But I had chosen Georgia for a reason – Georgia had liberal education laws. So, in 1979, I founded the nation's first proprietary school of physical therapy, and at the post-graduate level (or what we refer to as the 'post professional level') we issued a licensed but non-accredited MHSc in Orthopaedic Physical Therapy.

Graduates of my non-accredited and thus non-recognized degree had a hard time getting jobs in academia but some managed and they made the changes. They won respect for their knowledge and skills and so in 1993, 14 years later, my school was fully recognized and accredited by the United States Office of Education. I relocated to Florida, and four years later we became the University of St. Augustine. This now houses the largest physical therapy - and the third largest occupational therapy - school in the nation. In addition we have two other campuses: one in South Florida and one in San Diego, California.

The Future

Thus far in my presentation I have outlined by way of my experience in New Zealand and overseas, principally the United States of America, my observations of our movement from technician to a professional status depending on the nation. But the process remains far from complete and could unravel if progress is not continued and consolidated.

I earnestly believe that we are on the brink of achieving greatness as a profession, societal recognition that might have only been dreamed of half a century ago. You may think we are already there and I would not wish to argue against such thoughts. However just as in Sweden a century ago there were two equal health care providers – medicine for disease and physiotherapy for the physical functioning – that day may come again, but this time cooperatively and in the best interests of the patient.

New Zealand - as you well know – is a small country. Being small has many advantages. You have just two schools whereas the USA has 211 schools, you have one association, and one set of national laws and one national Board. Contrast this with the United States where the 50 states at times behave like 50 countries each with their own powerful legislatures, licensing and practice acts. In comparison with physiotherapy in NZ, in the USA the profession of physical therapy has to work with numerous bodies. It is easier for you to go work in Australia than it is for me to work in an adjacent state.

You have the opportunity here to show the rest of the physiotherapy world exactly how to prepare for the future. And by the rest of the world I refer to all of Asia and South America as well as to much of western and all of eastern Europe. In those nations autonomy is just a dream. If they can look to NZ as a model, if NZ puts forth that model and assists other nations to so develop this will be a significant contribution to healthcare.

In looking at this future there are many areas that could be addressed and in the interests of time I have chosen five of them.

1. The first is to once again define our *scope of practice*
2. Next, backing up practice with *meaningful research*
3. Then educationally we must consider the best way to put together a *clinical doctorate*
4. And of course we must further develop our will and ability to *market our profession*
5. And finally *maintain our autonomy*

Let me begin with:

1. The need to define our scope of practice.

In the USA, due in a large part to full employment for physical therapists, we have consistently failed to be concerned and thus to define our full scope of practice.

As a result of a chronic shortage of physical therapists – currently by some estimates to be in excess of 5,000…

- we lost pre and post natal care to nurses
- We lost sports physical therapy to athletic trainers
- we lost acupuncture to acupuncturists
- We lost chest physical therapy to inhalation therapists [now respiratory therapists – Ed].
- and we have lost certifying authority in the area of hands, aquatics and weight training.
- No doubt we will also lose veterinary physical therapy

There are lessons from the above for us here in New Zealand. If we do not define our full scope of practice, and ensure that we practice to our full scope, and provide adequate numbers to meet those needs, others will arise to meet the demand. Our voice as big as it may be now, will only be one of many that compete for media and legislative attention.

Sustained periods of job security breeds apathy and consequently an over-dependence on payers such as the ACC. If you are comfortable with what it provides today, you can be lulled into a complacency concerning tomorrow. Then when reimbursement changes negatively you will be hurt because of your dependency on one source. Nothing is constant. History shows that.

Instead we should constantly redefine and expand our scope of practice, scout for new opportunities and find new and competitive methods of delivering our services and being paid for them. So I advocate that we define a very broad scope of practice – or at least consider it. It begins with a definition of who we are. How we define physiotherapy to the world we serve, is at the heart of our scope of practice. May I suggest, for discussion, that we define ourselves as the profession of choice, the primary care practitioners for the restoration, maintenance and enhancement of the physical functioning of the individual.

"May I suggest… that we define ourselves as the profession of choice… for the restoration, maintenance and enhancement of the physical functioning of the individual"

The three words – *restoration, maintenance and enhancement* are of course not new but they do allow us to consider the full scope of practice.

By *restoration* we speak of our traditional and principle area of practice be it treating injured knees, spines or rehabilitating of the stroke or cardiac patient. Certainly we are the masters at physical restoration.

With regards *maintenance* - an area of increasing importance - what is our position? Maintenance speaks to wellness and maintaining the quality of life rather than losing it. Increasingly today health care management is passing from medical model of disease and medicine, to dysfunction and behavioral models of prevention and care.

While medicine may save lives no profession will speak to the quality of those lives more than does physiotherapy. Do we say "yes", we are the wellness practitioners, but are then not seen in health clubs, golf clubs, and gymnasiums and in the schools instructing and advising on health care? And will we ourselves be examples of a healthy and productive lifestyle? There has to be a better way than that offered by medical technology where spines are increasingly being fused and joints replaced. Our challenge is to show that physiotherapy is a better alternative and can provide and maintain a healthy, active and satisfying lifestyle.

As to *enhancement* this area is most typified by sports physiotherapy. Athletes may need restoration but they also seek enhancement. Do we have a role and to what extent? Are we not the best qualified to be the trainers and to work with the coaches on enhancing performance? Is that research in our journals or does it lie elsewhere?

It seems to me that there are more questions than answers. It is of course a challenge for the profession that we should engage. It's a challenge especially to the young, for it's their future. But who decides? Does the motive for change come from the clinicians, the Society [NZSP], academia or from the Board [New Zealand Physiotherapy Board]? Clearly it's all of these including our colleagues in medicine and the lay public.

2. Research

There can be no argument that research, especially research that shows our clinical efficacy, is not only essential to our future but also will determine the direction our future takes. Who should do this research is a big question.

At my University we have broken with tradition and do little in the way of researchWe are now of the opinion that the average faculty member and student is today incapable of producing papers of sufficient quality to make a difference to practice. This is because the bar, for those papers that will be considered in the meta-analysis and in forming the practice guidelines, has been raised beyond their reach. We have spent hundreds of thousands on research and have little to show for it.

Our literature is full of papers that grind out minor variations of established thought - how many more papers do we need on knee isokinetics - or of the transverse abdominus as a trunk stabilizer?

Enough already!

Thus our University has taken the position that only research projects that are well funded, directed by and carried out by experts in the field will have any chance of being considered to carry sufficient weight to influence the future of our profession. For this reason, we actively support the national Foundation for Physical Therapy, which is sponsored by the American Physical Therapy Association. Our philosophy frees our faculty to do what they are impassioned to do - and that is to teach hands-on ready-to-go skilled professional clinicians. The future employment of our faculty depends not on the research funds they bring in or papers they publish, but more on student and employer satisfaction with our product.

Supporting a research center is at least for us a much better alternative than requiring faculty and students to do research.

Here in New Zealand, the University of Otago has, I am sure you are aware, broken new ground by having achieved significant funding for the type of research that will determine our future. The study headed by Dr Haxby Abbott and Professors Baxter, Campbell, Robertson and Theis, wherein they will look at the long-term effect of physiotherapy to the hip and knee, is truly a first for physiotherapy. Studies of this nature are sadly lacking in our literature.

Medicine is full of such long-term outcome studies but few indeed are the studies in physiotherapy that show our effectiveness beyond a few weeks. It is one thing to show that six weeks of physical therapy as opposed to six weeks of medication can better reduce pain and disability returning the patient to work and recreation – but what at three years, five and ten years? As yet we simply do not know.

Where are the studies that show that physical therapy given intensely at first, with monitoring and boosting sessions over the decades that follow, not only results in less pain, more function, a better quality of life and less surgery but, above all, increased patient satisfaction and at less cost? This is what the New Zealand study will attempt to do.

"overnight we saw 20% unemployment in physical therapy… It could happen again – it could happen here"

3. The Clinical Doctorate

Here in New Zealand you have begun to discuss the clinical doctorate. Australia already has two programs up and running. You have an opportunity to study what the USA and Australia has done and to come up with a better plan by learning from their experience; and I trust that you will.

But first, why have a clinical doctorate at the entry point into the profession? Is it justified by the body of knowledge unique to physical therapy, and at a level that justifies the doctorate, or is it the inevitable consequence of degree inflation?

In the late 1990's physical therapy in the USA began to debate the topic of becoming 'a doctoring profession': i.e. that the entry-level professional qualification be at the clinical doctorate level. In a debate before the APTA, I was asked to take the position of being opposed to doctoral education at the entry point into the profession. I thus argued that a Masters degree was a sufficient degree and that the doctorate should only be conferred on those clinicians who demonstrated advanced clinical competencies. To my thinking, although we had a sufficient body of knowledge distinct to physical therapy, we did not have the evidence for that knowledge and we lacked and still lack a rigorous system to measure advanced clinical competencies as do exist within medicine with their respected specialty boards. I still hold to this position but, as a pragmatist, once the association voted to move to the doctorate my school was one of the first, if not the first, to do so.

Unfortunately many schools did not make substantial changes to their curriculum in terms of clinical content. Many tended to add that with which they were comfortable, such as research, and in the view of many, failed to emphasize that it is a clinical degree – a degree which should have little if any academic standing. It is a professional degree which ranks in academia as it should: below that of a post-professional masters.

Worse still: efforts to provide what we call a transitional doctorate - that is a doctorate in physical therapy for all those who in earlier years graduated with a diploma, bachelors or masters - was an abysmal failure. While we came up with a "consensus" on what that transitional program should entail in the way of course work and experience, the universities anxious to provide the degree to their graduates often watered down the requirements to where they became easy and inexpensive to acquire. Consequently, even some of the more rigorous programs had to change course toward this lower common denominator in order to remain competitive.

I would suggest that you consider that graduating at a master's level might be sufficient with the clinical doctorate being awarded when sufficient graduate studies and clinical skills had been proven. Perhaps the College would play a role here.

4. Marketing

I am sure many of us in this room can remember a day where to even mention marketing in a health science profession would be to raise a considerable ethical issue. Well today we are in competition: we are in competition for the hearts and minds of doctors, patients, legislatures and of course the media. We are also in competition with

chiropractors and those surgeons who would rather operate than rehabilitate.

We can win or we can lose in this arena but we must accept that we have to market our product and services in order to succeed and survive.

In the United States, in late 1998, in a last minute effort to balance the budget the Senate randomly removed $6 billion from physical rehabilitation: overnight we saw 20% unemployment in physical therapy. Never had we had unemployment and it happened without warning. Our research has simply not proven that we are essential.

Be aware also that, in the United Kingdom, less than 30% of last years graduating physiotherapy class are employed and this percentage is expected to grow worse. While education has been funded – employment has not.

Had we had the studies that show our effectiveness, had we marketed those studies effectively, thus proving our value to the public and legislatures, I have to believe that these events in the USA and the United Kingdom would not have occurred. It could happen again – it could happen here.

So it's about marketing. It's about marketing our effectiveness, but it's also about research; for without the evidence that we are effective and that we are essential, we have little to market. Therefore we should direct our research towards outcomes, cost savings and quality of life.

5. Finally maintaining and advancing our autonomy. This is at the core of a profession such as ours.

I am a firm believer in autonomy and have spent much of my career striving to achieve it for myself, for my profession and for my educational institution. Only when we free the therapist to evaluate the patient and to make the decisions as to treatment, and then require that they take responsibility for those decisions, do we free the therapist's mind and practice to grow and develop and thus better serve the patient/client.

But what role will we have in being able to prescribe pharmaceuticals, order lab tests and imaging studies, make referrals that enhance our efforts and hopefully save on health care costs by unfettered and complete direct access of patients to our services? Of course you have gained some of these services, more so than any other country of which I am aware.

However autonomy gained can unfortunately become autonomy lost. In the United States the medical profession, out of 'financial greed', is undermining much of the autonomy we have gained. Quoting from the *American Journal of Bone and Joint Surgery*, March 2008

> *"Medicine is no longer considered by a growing number of practitioners to be a profession but, rather, a business. It is dictated, governed, and discharged in the same manner that traditional businesses are conducted. Profit is becoming its raison d etre." (Sarmiento 2008)*

Over the last decade there has been an explosive growth in physical therapy practices owned by orthopaedic surgeons who then refer exclusively to their clinics often much more than they did when they did not serve to profit from self referral. They usually hire new graduates who are impressed to work in such an environment, but this drives out of practice many established, experienced and well qualified private practitioners – since when did health care become all about money and not about the value of what we offer? Referral for profit is certainly not in the best interest of the patient. I believe you would be mistaken if you thought it could not happen here in New Zealand.

Unfortunately all is not well here in New Zealand with regards autonomy. While you enjoy as much, if not more, independence than any other country clinically - the front door if you wish - your own profession is threatening to regulate you into a second class status at the back door. Autonomy can be hurt by over-governing bureaucracies no matter how well-intended So, in our policies on governance, we must continually strive to be involved in the decisions that affect our practice. Here I refer to certain requirements by the New Zealand Physiotherapy Board of which many of you may not be aware. The Physiotherapy Board has the responsibility to protect the public against unscrupulous and unqualified practitioners and practices, as does the Society. No question. However the Board is in danger - in my view and that of other speakers who have presented here in the recent past - of restricting your access to theories and practices that might advantage your future growth. Let me explain.

"It is censorship, it's a violation of academic freedom and a violation of free speech – it is a huge loss of professional autonomy...It must be addressed by this Society; and vigorously."

I have spoken in many countries and to many organizations. It is customary, once invited by a Society or organization, to provide the title of the presentation, an abstract for advertising, and a resume for the introduction. These I am happy to provide. That is as it should be. But never before have I been told that as a speaker I needed a temporary licence from the Physiotherapy Board before I would be allowed to speak before you here in New Zealand. A licence to speak to you, my colleagues?

Not sufficient that your Society - of which, incidentally, I am an Honorary Fellow - invited me: the Society had to apply on my behalf to the Board in order to obtain and pay for a licence for me to speak. What an embarrassment to them,

and such an affront to me and other international speakers.

What nonsense. But it did not stop there. I was asked to provide the Physiotherapy Board: a copy of my passport; a copy of all my practice licences; and the evidence for what I was about to present. The Board has even asked an American therapist for a copy of her marriage certificate!

When I failed to provide more than a copy of my passport the Board turned down your Society's application for me to speak at this conference. The Board asked for more information, such as (no doubt) my speech, but I refused to hand it over for I am a fervent believer in free speech and would never submit a non-scientific paper to even the suggestion of censorship.

But there is more. I was informed by the Board that should they grant me this temporary licence, it would not cover me for other speaking engagements in New Zealand. In other words I am not permitted to speak to students at either of the schools or to a gathering of therapists in, for instance, your clinic, as I am not licensed to do so while here in New Zealand.

This is an outrage.

It is censorship, it's a violation of academic freedom and a violation of free speech – it is a huge loss of professional autonomy. [applause – Ed.]

It must be addressed by this Society; and vigorously. [prolonged applause – Ed.]

Throughout history well-meaning governments and regulating authorities have set laws and regulations not in the best interests of the citizenry. This is such a time.

The Society, I know, is embarrassed by these events and has been unable to change them. But change them they must and we must support them in their efforts.

New Zealand, I know, has a history of over-regulation. That is why in 1963 I joined the New Zealand Constitutional Society because of the restrictions to free speech that are ever present in New Zealand. Whether, as in the 1950's, it was restricting the music we could hear on the radio and bring into the country, or as it is today in restricting speakers like me, or as reported in the New Zealand Herald, telling our athletes what they can and cannot say before during and after the Beijing Olympics. Not so the Australian and British Teams, who have refused to be stifled and insist on the rights to free speech (Korporaal 2008).

In my mind the right to free speech is essential to a robust democracy and serves as a safeguard to society. No one has ever successfully restricted me from speaking out on manipulation – but turn the clock back to 1960's and I suspect the Physiotherapy Board, with today's rules might well have endeavored to do so. Likewise Robin McKenzie and Brian Mulligan would never have been allowed to spread their theories and innovative treatment approaches to the betterment of patient care worldwide if other countries adopted such restrictive rules as requiring a licence to speak. I am sure this embarrassment will be addressed. I hope I have helped.

Summary and Close:

So ladies and gentlemen let me now summarize and close. Physiotherapy continues to have a bright and wonderful future. We have come a long way in just one generation where we were technicians under the control of the medical establishment to the present where we are partners in health care and the recognized experts in the restoration, maintenance and enhancement of the physical functioning.

We must carefully defend our autonomy while at the same time seek to define and expand our scope of practice and to develop the research, education and leadership that will be needed to advance our present position to where the recognition we accord ourselves is shared by the universe at large .

Thank you

[standing ovation – Ed.]

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Response to: Paris, SV (2008): Autonomy and the future of physiotherapy. New Zealand Journal of Physiotherapy. 36(2): 67-75

The Physiotherapy Board appreciates the opportunity to respond to aspects of the keynote address delivered by Professor Paris above. That address contained comments about the difficulties Professor Paris encountered with the registration process as a physiotherapist visiting New Zealand in a professional capacity.

The Board fully recognises the importance of having internationally respected physiotherapists visit New Zealand for the purpose of presenting lectures, courses and workshops and has no desire to put unnecessary obstacles in the way of professional development and progress. Nor has it ever sought to stifle professional growth by restricting access to the best of knowledge imparted by respected scholars and clinicians. It is timely therefore to explain the reasons for regulation of visiting presenters before clarifying the Board's current position and intentions in this regard.

It is easy to envisage shortcuts for high profile reputable people. The Board has however a duty and the ultimate responsibility of protecting the public from doubtful practitioners and others who might represent themselves as having competencies in physiotherapy outside the scope that their peers would recognise. In so doing, the Board also protects the profession from those who might denigrate or destroy the image of a physiotherapist.

Parliament, through the Health Practitioners Competence Assurance Act 2003 (HPCA Act) set up regulatory authorities to protect the health and safety of the public by ensuring that health professionals are competent and fit to practice. It did this by a strictly defined registration system which also, incidentally, protects each health profession by ensuring its reputation does not suffer at the hands of incompetent practitioners.

The legal advice taken by the Physiotherapy Board prior to the inception of the HPCA Act indicated that visiting presenters required registration by the Board under the HPCA Act because they would be "practising a profession" by virtue of their delivery of physiotherapy services. In the early days of the new legislation, following that advice and desirous of correctly carrying out its duties under the new Act, the Board developed policies and procedures that with hindsight, saw the regulatory pendulum swing toward a stringent registration system. This robust system was designed to protect the public and the profession from poor practitioners and charlatans circulating in our country and purportedly promoting physiotherapy knowledge and skills.

In the light of experience some modifications were made prior to the 2006 NZSP conference with a positive response to the changes being expressed later. Since the latter half of 2007, the Board has been reviewing the requirements further. Benchmarking against other regulatory authorities in New Zealand and overseas has produced confirmation that a degree of registration for visiting presenters is required by many other regulatory authorities. It has become apparent however, that a less stringent approach is possible, a stance supported by more recent legal advice. Further modifications are being evaluated and the pendulum is now poised to swing toward the other direction. The Board will keep in touch with the profession as it seeks a balance between its current policies and a more modified approach that continues however, to protect the public and the profession.

The Board agrees with Professor Paris that physiotherapy has a bright and wonderful future. The Board too, supports the concept of autonomy. The confidence that the public and the profession has in its regulatory body is one reason that the profession has autonomy. The Board believes there is no tension between its duty of accountability to the public, including the profession, and that of the growing maturity of the profession.

Hilary Godsall
Chair, Physiotherapy Board of New Zealand

Response to: Paris, SV (2008): Autonomy and the future of physiotherapy. New Zealand Journal of Physiotherapy. 36(2): 67-75

Thank you for the opportunity to respond to Professor Stanley Paris's keynote address. The New Zealand Society of Physiotherapists Inc continues to working positively with the Physiotherapy Board of New Zealand for the benefit of the profession overall and the patients we treat.

In our discussions we recognise the differing roles of the two organisations. The society promotes a self-regulating and advancing profession. The Board is required by the Health Practitioners Competence Assurance (HPCA) Act 2003 to protect the health and safety of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their professions. The differing roles do cause tensions, particularly in regard to the autonomy of the profession. These tensions are not confined to the physiotherapy profession and are being highlighted by other professional groups too, in the current Ministry of Health review of the HPCA Act.

The Society will continue to advocate that the requirements placed upon the profession under the HPCA Act be set at a level which takes into account both the self-regulation of the profession and an assessment of any potential of risk to the public.

Jonathan Warren
President
New Zealand Society of Physiotherapists