Professional issues for physiotherapists in family-centred and community-based settings

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This paper reports results from a qualitative study of physiotherapists in a community-based and family-centred setting in which a growing awareness of the family-centred approach accompanied the transition from an institutional structure to a predominantly community-based structure. The goal was to gain insight into how a family-centred philosophy was working and to explore the benefits and dilemmas for physiotherapists in such a setting. Semi-structured interviews were conducted with 10 physiotherapists working with children with disabilities. Analysis of the results against a continuum of family control versus physiotherapist control showed that physiotherapists saw their roles as working with the family to discuss shared goals. However, qualitative analyses showed tensions between the policy of family involvement and another influential policy in physiotherapy: evidence-based practice. Further, there were tensions if the desires of the family could not be matched with available resources. The results show benefits and barriers to working in a community-based, family-centred approach. Barriers included practical dilemmas, policy dilemmas, and career dilemmas. This paper argues that, while family-centred practice is supported by the literature and physiotherapists, significant policy and professional issues need to be addressed before such practice can be fully adopted. [Litchfield R and MacDougall C (2002): Professional issues for physiotherapists in family-centred and community-based settings. Australian Journal of Physiotherapy 48: 105-112]

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Introduction

Moving away from the medical model As physiotherapists have emerged from under the cover of referrals and direction from medical practitioners to be first contact practitioners in their own right, they have increasingly emphasised proving their worth as a vital part of the health care system. In order to do this, physiotherapists have remained firmly grounded in the medical model of health and have more recently focused on evidence-based practice (Ritchie 1999).

The medical model focuses on decreasing morbidity and mortality by providing illness care and medically-managed behaviour change (Baum 1998). Consistent with the medical model, quality physiotherapy interventions are considered to be those grounded in scientific knowledge of physiology and pathology; addressing physical problems identified by standardised assessment and diagnostic procedures; based on techniques for which they have been specifically trained; with outcomes which can be measured (Lawler 1997). Clearly, high quality health care benefits physiotherapy clients and the use of evidence-based practice is one way to ensure patients are not subjected to ineffective treatment regimes (Ritchie 1999).

However, physiotherapists are increasingly working in community-based settings influenced by principles of primary health care such as community participation, partnership with clients and their families and intersectoral collaboration (Baum 1998). The primary health care context can provide both benefits and dilemmas for physiotherapists who have been strongly influenced by the medical model. In particular, practice informed by the emerging principles of primary health care should demonstrate a dynamic and culturally appropriate approach that takes account of lay assessments of behaviour and their basis in popular culture. Lay assessments involve a complex process of weighing up the evidence about health and illness, particularly the short and long-term consequences for the individual. Trade-offs are made between good (healthy) behaviour and bad (unhealthy) behaviour to balance out overall health. In this process, individuals often draw on different frames of reference from those of health professionals and scientists (Backett and Davison 1992).

Moving to family-centred approaches In line with the principles of primary health care, physiotherapists are moving towards community-based and family-centred approaches (for example when offering services to children with disabilities). Within these approaches, they aim to achieve meaningful and productive partnerships and effective services with clients (Brown 1997). Brown et al (1997) define a family-centred focus as requiring attitudinal changes that reflect a commitment to follow the lead of the family and support their vital role rather than impose professional decisions. Brown et al (1997) also
suggest that a family-centred approach should allow a family to assert its own level of involvement, requiring the physiotherapist to work at the level of involvement requested by the family.

Brown et al (1997) describe a seven-level hierarchy of family-physiotherapist involvement in which families with children with disability are given progressively greater control. The seven levels described are: Level 1 - no family involvement; Level 2 - family as informand; Level 3 - family as therapist’s assistant; Level 4 - family as co-client; Level 5 - family as consultant; Level 6 - family as team collaborator; and Level 7 - family as director of services.

Brown et al (1997) believe that family empowerment and family-centred principles are embraced at Level 6 but that Level 7 demonstrates ultimate family control where the family unit becomes the supervising co-ordinator and consumer of therapeutic intervention. At this level, the physiotherapist’s role is transformed to one of a resource person and facilitator. This seven level hierarchy is broadly similar to hierarchies found in the primary health care literature, such as Arnstein’s (1969) ladder of citizen participation.

However, there is more to adopting a family-centred approach than locating oneself on such an hierarchy or continuum. The term “family-centred” can be confusing unless it is used precisely and distinguished from more general terms such as “family-oriented” and “family-focused”. Family-centred approaches involve policy and programs that combine family support principles with appropriate paradigms and practice (Dunst at al 1991). Family support principles are statements of beliefs about how supports and resources ought to be provided in a family-centred manner. Paradigms are models that classify programs along the lines of the continua and hierarchies reviewed above. Practices involve ways of acting or behaving that are consistent with the beliefs and paradigms underpinning the family-centred approach.

Challenges for physiotherapists Moving towards a family-centred focus creates significant challenges for more traditionally trained physiotherapists in the way they gain and utilise information from patients and family members. Physiotherapists now are asked to find out what form of therapy the family wants for their child. As a result, the physiotherapist may no longer be predominantly an expert who diagnoses and then provides therapy, but is frequently a resource to a family whose knowledge and judgments are to be respected.

The primary health care literature consistently provides examples whereby community participation is seen as a challenge to the role of the professional, since bureaucracies regard highly the possession of technical expertise for promotion through the hierarchy. The notion that the community possesses valuable knowledge, albeit of a different kind, through living in a particular region or experiencing a specific health condition may be considered a threat to the authority of the expert professional (Bates and Lapsley 1985). Accordingly, physiotherapists have highlighted the professional dilemmas associated with the family-centred approach where, in the minds of some, empowerment of families means professionals relinquishing all their expertise and responsibilities and expecting the parents to make all the decisions. Professionals are warned against backing away from providing expertise and instead are urged towards mutuality of respect, where parent’s knowledge and expertise is valued along with that of the professional (Marfo 1998). There has also been acknowledgement of the threatening nature of the changes professionals are being asked to make and the new skills they require for a family-centred approach, particularly if their training has been almost exclusively child or patient focused (Bailey 1992). Similarly, these changes in role may also threaten the family’s confidence in, or habitual way of relating to, the paediatric physiotherapist.

The family-centred approach is an approach to practice that can be either community-based or institution-based, or a combination of the two. However, the location and structure of a service may influence the nature of therapist-family relationships and so there is an interrelation between these two concepts. It has been suggested that further research into the practical implications of family-centred care is needed, involving an analysis of day to day perspectives, assumptions and practical dilemmas facing practitioners and families in their struggle to create effective partnerships (Lawler 1997).

The current study This paper reports results from a qualitative study of physiotherapists in a community-based and family-centred setting in which a growing awareness of the family-centred approach accompanied its transition from an institutional structure to a predominantly community-based structure. The aims of the research were to

• examine how a family-centred philosophy was incorporated into professional practice; and
• the benefits and drawbacks of family-centred practice for physiotherapists.

Method

Context and background The research was conducted by a physiotherapist at the Crippled Children's Association (CCA) in Adelaide, South Australia. The Association was approached for permission to engage in observation of physiotherapists in their work. During the period of observation, a number of issues surfaced regarding putting a family-centred philosophy into practice. Further permission was then sought from CCA management to engage in a further study to investigate these issues.

Since 1939, the CCA has provided services for children with a physical disability and their families. Early services were based at a centralised location but since 1993, the CCA has become mostly community-based. The CCA
employs 22 physiotherapists either full or part time and serves approximately 940 clients (Crippled Children’s Association 1999). Services provided by the CCA include physiotherapy, occupational therapy, speech pathology, psychology, paediatric rehabilitation, orthotics, mobility and wheelchair maintenance, specialised seating and assistive technology, as well as both clinical and technological research and development.

**Setting and participants** Semi-structured interviews were conducted individually with 10 physiotherapists from various regions of the CCA, including recent graduates, base grade physiotherapists with more than two years experience and senior physiotherapists. The sample was selected from a list of the 22 physiotherapists employed at the CCA to represent the range of length of service, seniority and the region covered by physiotherapists. Table 1 shows that many in the sample were very experienced, although comparatively new to the CCA.

Eleven letters of invitation were sent out and one physiotherapist declined the invitation. Four of the physiotherapists worked full time for the CCA and the remaining six worked between half time and full time. Table 1 indicates the length of time the participants had worked at the CCA and when they graduated from physiotherapy school.

**Procedure** Participants were invited to take part in a one-off face-to-face interview regarding their thoughts, feelings and experiences of working in a community-based setting that aimed to be family-centred. Participants were asked to return a consent form to confirm their participation. They then received a phone call after one week to answer any questions and arrange a convenient time and location for an interview.

The questions in the semi-structured interviews were developed from the participant observation and focused on the practice, thoughts and feeling of the physiotherapists regarding family-centred practice and the community-based approach of the CCA. The interview began with the question “In your work, what do you see as the most important outcome of your contact with the family?” This question, from Brown et al (1997), was included in order to place the respondents into a hierarchy of family-therapist involvement.

Subsequent questions explored the benefits and disadvantages of working in a community-based setting for physiotherapists and clients. Participants were also asked whether they felt like physiotherapists, what was and was not their role and how their work was considered by physiotherapists outside the CCA. In addition, they were asked about professional development training and support, and their feelings and understanding of family-centred practice.

These open-ended questions were followed by prompts and further questions for detail and clarification. Hand-written notes were taken as completely as possible during the interview and, according to best practice, expanded upon post-interview (Patton 1990). It was decided to use handwritten notes in order to combine the interviewer’s participant observation with the busy practice of community based physiotherapists, many of whom worked part time. Further, it was agreed with the CCA that using notes was more natural and less formal than arranging interviews in a venue where a tape-recorder could be used.

The notes were typed up as soon as possible after each interview, labelled with the respondent’s details and then checked with handwritten notes. Multiple copies were made so the data could be analysed twice as described below, each time using coloured markers to code for themes. The data were first analysed according to guiding questions from the literature reviewed earlier in this paper, in particular “Which level of client/physiotherapist interaction does this respondent most closely resemble? What are the dilemmas facing physiotherapists in this working environment?” Next, the analysis looked for themes based on recurrent ideas, concepts or problems that appeared. There was insufficient difference in responses from the different sub-groups within the sample to warrant detailed comparisons across sub-groups. Therefore the results reported below are from the whole sample and do not differentiate between, for example, education level or years of experience of physiotherapists.

**Results**

*Family-centred philosophy and professional practice* In order to analyse the interview data, the seven level hierarchy of Brown et al (1997) was grouped into three categories. The first category comprised the first two levels of the hierarchy and was termed “the biomedical approach” because it focused on the client, their physical problems and the physiotherapist’s judgment about the most appropriate intervention. The second category comprised Levels 3, 4 and 5 of the hierarchy and was termed ‘the family as assistant and/or consultant’ model. This category acknowledged the importance of family involvement in order to make any treatment appropriate, functional and
achievable. The families’ needs were taken into consideration and they assisted in the implementation of therapy. This approach requires therapists to have an understanding of family systems, cultural, developmental and socio-economic factors. It also requires good teaching and communication skills. The third category was termed ‘the family-directed’ approach and comprised the final two levels of Brown et al’s (1997) hierarchy. Here the therapist truly shared power with the family, which was involved fully in the planning, goal development, intervention and evaluation. The family decided what services would be involved and how the family would be involved to achieve the family’s goals. This approach required the physiotherapist to be a resource person and consultant for which highly developed collaboration skills were essential.

On the basis of the interview, all respondents were classified in the second category, “family as assistant and/or consultant.” Physiotherapists’ responses were consistent and similar and demonstrated a strong emphasis on the role of the family in every aspect of the child’s life including their therapy and agreed that any interaction with the child must take into account the needs, goals and abilities of the family. However, interview responses suggested that, despite the adoption of policies promoting family-centred practice, the current resources available in the CCA did not fully enable family involvement at the third category level of ‘family-directed services’. Respondents argued that a family could not have total control over services unless there was a larger range of services available both in the CCA and in other agencies. Representative quotations are:

“It’s an agency dilemma. How do you go with what a family wants when time and resources are limited? Parents often want more.”

“We don’t do family-centred practice because of the economic situation. The client can’t choose which physiotherapist or how often. These are meaningless choices. We are giving lip service to family-centred practice.”

Although the notion of family-centred practice was widely regarded as a positive direction, some physiotherapists expressed reservations about operating only at the “family control” end of the continuum. They suggested that this might not be the most effective model of practice and that physiotherapists require skills to operate throughout the categories or levels of the hierarchy depending on the situation. This indicates the highly skilled and demanding role physiotherapists play in an organisation such as the CCA. It is necessary for therapists to be clinically skilled and equipped with the ability to make and express professional judgments (the biomedical approach); acknowledge the importance of the family and skillfully involve them as assistants and consultants (family as assistant/consultant approach); and enable the family to direct intervention when that is what they need and choose and as structures allow it (family-directed approach).

Table 2. Perceived benefits of working in a community-based setting.

<table>
<thead>
<tr>
<th>Benefit</th>
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<tr>
<td>Gaining a realistic perspective on a family’s life.</td>
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<tr>
<td>Closer relationships with families</td>
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<tr>
<td>Easier to assess priorities</td>
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<tr>
<td>Family does not have to travel</td>
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<tr>
<td>Family in charge more</td>
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<tr>
<td>A more effective approach to therapy</td>
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<tr>
<td>Therapist gets out of the office</td>
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<tr>
<td>Contact with the various people dealing with child in school or home</td>
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<tr>
<td>Greater client comfort in own environment</td>
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<tr>
<td>Able to see the family dynamics</td>
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<tr>
<td>Empowering to parents which translates to greater chance of success for intervention</td>
</tr>
<tr>
<td>Parents more involved in therapy</td>
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<tr>
<td>Flexibility</td>
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<td>Disabled are more a part of the community</td>
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**Family-centred philosophy: benefits and drawbacks**

Physiotherapists in the study were not arguing for a professional-centred versus family-centred approach but in favour of a melding of the two in a “both/and approach.” Many of the respondents in this study clearly indicated potential professional dilemmas when considering operating entirely at the “family-centred” level. They felt this could invalidate their professional knowledge and skills and that many parents want and expect a professional to use their skills and knowledge to direct them in making the best decisions for their child’s wellbeing.

Tables 2 and 3 summarise, in no particular order, the way physiotherapists in the study described the benefits and disadvantages for both the physiotherapists and families in the transition towards a family-centred and community-based approach. Most respondents felt that despite the many difficulties of working in the community, seeing clients in their own environments added essential dimensions to the therapy and the quality of relationships. Many expressed a desire to be able to combine the benefits of both site-based and community-based services.

Table 3 summarises the disadvantages of working in a community-based setting as described by the respondents. At times the very things the respondents mentioned as benefits of the community-based setting for their clients were considered to be disadvantages for themselves. For example, many felt that while it was good for families to have more control, they as physiotherapists had to struggle with the feeling they therefore had less control.

The double-edged and often conflicting nature of the benefits and disadvantages reflected the sense of dilemma...
Practical dilemmas. The practical dilemmas, associated with clinical skills and roles or relationships with clients, have arisen from the shift away from the more traditional professional/client model of practice. Many physiotherapists in the study described as a challenge and potential source of stress the task of determining their role and relationship with the family. Others felt quite happy and confident in their ability to negotiate these roles. The practical dilemmas in this section relate to negotiating family roles, the need to be multi-skilled, the place of the physiotherapist in daily life, following the family’s informed decisions, location and workload.

“It’s a struggle ... What’s a family outcome versus a physio outcome? ... It’s hard when families don’t have much idea of what they want. Making these decisions on how to interact with a family makes me stressed.”

The need to be multi-skilled caused some tension.

“Sometimes when you go out on your own you can’t neglect the other areas, you need to be multi-skilled in early intervention. It would be great to learn more of the other disciplines.”

Respondents faced a dilemma when working with families for whom physiotherapy was not the highest priority.

“It takes the ego away ... physiotherapy is not always the most important thing in peoples’ lives.”

The physiotherapists felt very strongly that enabling informed decision making by families was a primary role for them although following though with a family’s decision may not be easy.

“I’m normally happy to go with their priorities as long as it’s an informed decision and doesn’t seem contraindicated.”

“You need to give information for them to make decisions. There will be times when a family makes a detrimental decision - what do you do?”

Another practical dilemma was specifically concerned with the location of the physiotherapy service. Many respondents expressed a desire to include a semi site-based approach rather than be completely community-based, in particular to deal with the danger of isolation reducing both professional skills and access to equipment.

“Sometimes to do assessments and treatment effectively you need specialised teaching areas and equipment and a distraction-free place”.

“One drawback is we are always on our own - no second opinion”.

Many respondents felt the strain of an often heavy workload and work related stress.
Career dilemmas Respondents nominated career dilemmas that arose from the move away from traditional clinical physiotherapy work to the family-centred practice and the community-based setting. They expressed concern about the loss of ‘hands-on’ physiotherapy skills due to the decreasing opportunities for daily practice because of the other demands in their work role. At the same time, the therapists felt they were expected to be the expert in certain situations. Some concern for future employment was also expressed. The career dilemmas discussed in this section relate to skill maintenance, skill development and professional recognition.

“I have lost skills in some areas and I would find it difficult to gain employment outside of this agency and that worries me professionally”.

“We don’t consolidate skills but are required to do hands-on therapy and teach others at times without an opportunity to do it a lot yourself.”

Some respondents concerned that new graduates working for the CCA might be limiting the scope of their experience too early in their career and that new graduates needed a broad skill base that may be hard to build up at the CCA.

“I’m anxious for the new graduates. How do they build up the expertise they need?”

Some respondents felt they received little recognition in their position, including recognition by other physiotherapists and the Australian Physiotherapy Association. Others felt that an organisation such as the CCA focusing on family-centred practice would create difficulty recruiting physiotherapists, leading them to express frustration that what they saw as the difficult and highly skilled nature of their job was not acknowledged throughout the profession.

“Paediatrics and the CCA have a poor image among some physios. It’s not ‘high flying’ compared to other physio jobs. … I see my work as more complex and requiring skill, but others don’t see the problem solving involved.”

Policy dilemmas The policy-related dilemmas included issues both for the physiotherapists and for the CCA as an organisation. These dilemmas were particularly highlighted in the conflict some respondents felt existed between the emphasis on evidence-based practice and the policy of family-centred practice. Evidence-based practice is a significant movement arguing an ethical imperative to provide patients with the best possible treatment as well as a requirement to demonstrate that, in the current economic and political climate, physiotherapy services are worth ‘purchasing.’ There is a push for physiotherapists to discontinue therapies when evidence indicates a lack of efficacy, and to ensure optimal health outcomes if they are to remain a credible and valued member of the health care team (Research Committee (Victorian Branch) of APA and Contributors 1999).

The push for evidence-based practice has provided a dilemma for respondents who wish to remain credible in their profession while at the same time feeling obliged to continue therapies which families have requested but for which there is little evidence of efficacy. They wondered whether their attempt to be family-centred in their work could in fact lead to poorer outcomes. Their decisions were made more difficult by the complexities involved in obtaining the required evidence to justify practices in a community-based paediatric service. This is because, while the randomised controlled trial is often the gold standard of evidence, some see it as having a limited role in assessing outcomes in rehabilitation (Andrews 1991). One participant expressed the problems as follows:

“Family-centred practice conflicts with evidence-based practice. By being purely evidence driven, families are going to miss out on needs that can’t be measured ... But it’s unprofessional to use resources for bad outcomes if you know it will be unsuccessful.”

Another respondent thought the trend for evidence-based practice was positive and reaffirmed to her the importance of using professional knowledge and skills in a measurable way. In contrast to to other participants, she felt this could be included in family-centred practice and stressed it was important to meld the two by using valid and relevant measures that are meaningful to families. This is consistent with the idea of a physiotherapist operating across all levels of Brown et al’s (1997) hierarchy of client/physiotherapist control.

Another policy related dilemma arises from the restrictions on family control and choices because of the financial, physical and personnel resource limitations under which the CCA and other community-based services operate.

Discussion and conclusions

This study describes professional issues that have come to light as physiotherapists reflect on how the family-centred philosophy has been put into practice in a community-based setting. The physiotherapists perceived both benefits and disadvantages from working in this way. They felt that these benefits came at a cost in that they came with practical, career and policy related dilemmas.

The nature of the dilemmas and complexities associated with working in a family-centred and community-based setting that were expressed by the participants of this study are similar to those expressed in the literature (Lawler 1997). Shifting decision-making power to families requires professionals to spend considerable time negotiating decisions with families, which lessens the “hands-on”
treatment time. This may threaten many notions about best practice. In the context of the very topical subject of evidence-based practice, it is frequently assumed that for best practice we need evidence which consists of ‘scientifically’ evaluated interventions judged through objective criteria. However, we are reminded that we also need input from patients in order to deliver “patient-centred care” which is surely essential for the best outcomes of physiotherapy intervention (Ritchie 1999). In the present study, physiotherapists had adopted many of the beliefs and paradigms underpinning family-centred practice, but felt the need to develop what have been described as their practice skills (Dunst at al 1991).

Lawlor and Mattingly (1997) describe how many of the dilemmas for practitioners in this field reflect the struggle to include families in a more substantive way while still attempting to fit into the norms and values associated with the medical model. Maybe some of these dilemmas will be lessened as the expert-driven values and culture of the medical model are either modified or replaced by the influence of participatory family-centred and primary health care approaches.

Further, as Lawlor and Mattingly (1997) argue, in the family-centred model of practice the focus broadens from a physiotherapy “problem” to cover more aspects of a family’s life. As this happens, physiotherapists can become less clear about their role and become concerned about shifts in decision-making power and responsibility. Some of the physiotherapists in this study expressed these concerns, stating that their role no longer resembles that of a physiotherapist as they were trained. Many of these concerns can be addressed by increasing the emphasis in training and professional development on family-centred and primary health care approach, with particular reference to the implications for the physiotherapist’s role and skills.

The insights from this study were similar to another study involving focus groups of physiotherapists at the same organisation (Raghavendra 1999). Both studies demonstrate the enjoyable but demanding and stressful nature of work and the importance of addressing the priorities and needs of the whole family. Other common points included: the fear of loss of professional credibility in some understandings of family-centred practice; the importance of informed choices for families; the need to promote the CCA as a positive workplace for physiotherapists; confusion about expected roles; difficulty in responding to parents’ wishes within the limits of the available resources; and the desire for ongoing training and support in a range of areas.

Obviously, these are difficult issues for both practitioners and organisations. We therefore need research into the best ways for organisations to create the capacity for physiotherapists to adopt family-centred practice. One model is provided by a recent study that asked the chief executive of a local government what features of the organisation supported the introduction of a primary health care approach to physical activity (MacDougall at al 2002). The dilemmas facing paediatric physiotherapists working in a family-centred and community-based setting need to be addressed in imaginative and sensitive ways that meet the needs of families and physiotherapists. At the same time, the physiotherapy profession should encourage and support this demanding, highly skilled and many faceted type of work that physiotherapists engage in at the CCA. This can best happen if there is continuing evaluation and analysis of the practical application of approaches such as ‘family-centred practice.’ However, the results and recommendations from our study must be understood within a health system and professional culture that also embraces evidence-based practice. Qualitative research methods are ideally suited to exploring the evidence for benefits and challenges of family-centred approaches for clients and physiotherapists, especially in an area of health practice that does not lend itself easily to the randomised controlled trial.

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References


Lawler M and Mattingly C (1997): The complexities...


