

## Closing the Gap Between Ethics Knowledge and Practice Through Active Engagement: An Applied Model of Physical Therapy Ethics

Clare M. Delany, Ian Edwards, Gail M. Jensen, Elizabeth Skinner

C.M. Delany, PhD, MHLth&MedLaw, MPhysio, BAppSciPhysio, is Senior Lecturer, Department of Physiotherapy, School of Health Sciences, The University of Melbourne, Parkville 3010, Melbourne, Victoria, Australia, and Clinical Ethics Fellow, Children's Bioethics Centre, Royal Children's Hospital, Melbourne. Address all correspondence to Dr Delany at: c.delany@unimelb.edu.au.

I. Edwards, PhD, GradDipPhysio, BAppScPhysio, is Lecturer, School of Health Sciences, University of South Australia, Adelaide, Australia.

G.M. Jensen, PT, PhD, FAPTA, is Dean of the Graduate School, Associate Vice President of Academic Affairs, Professor of Physical Therapy, and Faculty Associate, Center for Health Policy and Ethics, Creighton University, Omaha, Nebraska.

E. Skinner, BPhysiotherapy(Hons), is Senior Physiotherapist, Intensive Care, Department of Physiotherapy, School of Health Sciences, The University of Melbourne.

[Delany CM, Edwards I, Jensen GM, Skinner E. Closing the gap between ethics knowledge and practice through active engagement: an applied model of physical therapy ethics. *Phys Ther.* 2010;90:1068-1078.]

© 2010 American Physical Therapy Association

Physical therapist practice has a distinct focus that is holistic (ie, patient centered) and at the same time connected to a range of other providers within health care systems. Although there is a growing body of literature in physical therapy ethics knowledge, including clinical obligations and underlying philosophical principles, less is known about the unique ethical issues that physical therapists encounter, and how and why they make ethical decisions. As moral agents, physical therapists are required to make autonomous clinical and ethical decisions based on connections and relationships with their patients, other health care team members, and health institutions and policies. This article identifies specific ethical dimensions of physical therapist practice and highlights the development and focus of ethics knowledge in physical therapy over the last several decades. An applied ethics model, called the "active engagement model," is proposed to integrate clinical and ethical dimensions of practice with the theoretical knowledge and literature about ethics. The active engagement model has 3 practical steps: to listen actively, to think reflexively, and to reason critically. The model focuses on the underlying skills, attitudes, and actions that are required to build a sense of moral agency and purpose within physical therapist practice and to decrease gaps between the ethical dimensions of physical therapist practice and physical therapy ethics knowledge and scholarship. A clinical case study is provided to illustrate how the ethics engagement model might be used to analyze and provide insight into the ethical dimensions of physical therapist practice.



Post a Rapid Response to  
this article at:  
[ptjournal.apta.org](http://ptjournal.apta.org)

Physical therapists are rehabilitation experts who provide health services within health care dimensions of promotion, prevention, and intervention to people, communities, and populations.<sup>1,2</sup> The physical therapy profession began as an adjunct to medical practice.<sup>3-5</sup> This link extended to a reliance on the clinical and ethical decisions of the referring physician.<sup>6</sup> With increasing professional autonomy and independence in clinical decision making and judgments, physical therapists face increasingly complex ethical issues in their professional practice.<sup>7</sup> These ethical issues include understanding and balancing the needs of patients and those of the patients' families and other professionals and working within the constraints and opportunities afforded by health policies and institutional systems and structures.<sup>7,8</sup> In this context, physical therapists have moved away from a reliance solely on the medical profession to guide their ethics knowledge and decision-making frameworks. They have built their own body of literature about the nature and scope of ethics and ethical decision making in different areas of practice.<sup>9-13</sup>

In this article, we identify the development and focus of ethics knowledge in physical therapy over the last several decades and highlight links and gaps between ethics knowledge as discussed in the literature and the specific ethical dimensions of physical therapist practice. We then propose an applied ethics model, titled the "active engagement model," that seeks to integrate clinical and ethical dimensions of practice. Finally, we use that model to analyze a clinical ethics case scenario.

## Types and Dimensions of Ethics Knowledge in Physical Therapy

In a comprehensive, retrospective analysis of physical therapy ethics knowledge from 90 English-language articles published between 1970 and 2000, Swisher<sup>14</sup> found 2 broad approaches to defining and discussing ethics. Forty-three percent of the articles analyzed 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."<sup>14(p694)</sup> Of these articles, 60% used biomedical principles as a guide to ethical behavior. Thirty-three percent of the articles used a social scientific or descriptive ethics approach, focusing on the exploration of human ethical behavior rather than on how people "ought" to behave. 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's 2002 review<sup>14</sup> identified 3 main themes in the steady growth in the body of knowledge of ethics between 1970 and 2000:

1. 1970-1979: establishing the role of the physical therapist as an ethical decision maker
2. 1980-1989: applying philosophical principles to ethical problems
3. 1990-2000: the evolving relationship between physical therapists and patients

However, the review also identified gaps in the physical therapy ethics knowledge base. Specifically, Swisher found that few studies had attempted to define the ethical issues that physical therapists routinely encounter in their everyday practice (Tab. 1).

In a follow-up to Swisher's review, Carpenter and Richardson<sup>15</sup> identified an additional 27 peer-reviewed articles about physical therapy ethics published between 2000 and 2007. Their review demonstrated a partial closing of the gap between theory and practice due to an increase in research about the "unique ethical issues encountered in physical therapy practice, factors that affect ethical action, the role of the physical therapists as a moral agent and the types of moral reasoning being used by physical therapists in practice."<sup>15(p373)</sup> However, the authors again highlighted ongoing gaps about factors that influence everyday ethical decision making within specific contexts of physical therapist practice (Tab. 1).

## Ethical Dimensions in Clinical Physical Therapist Practice

Poulis<sup>16</sup> recently discussed these theory-practice gaps in physical therapy, noting a degree of silence about the specific nature of physical therapist practice and any associated ethics scholarship. Poulis described 3 distinctive ethical issues that emerge from clinical physical therapist practice. These ethical issues derive from inherent goals and ideals of the physical therapy treatment encounter, the interdisciplinary nature of the clinical environment that requires decisions to be made about the best interests of patients within a web of health professional teams, institutional and health policies, and patient/family cultures and relationships.



Available With  
This Article at  
[ptjournal.apta.org](http://ptjournal.apta.org)

### • [Audio Abstracts Podcast](#)

*This article was published ahead of print on May 6, 2010, at [ptjournal.apta.org](http://ptjournal.apta.org).*

**Table 1.**  
Gaps in the Ethics Literature in Physical Therapy

Author	Key Findings	Gaps/Areas for Growth and Research
Swisher <sup>14</sup>	Review of ethics articles (1970–2000) 1. Philosophical approach used by 43% of ethics articles analyzed, and 60% of these used biomedical principles 2. Social scientific/descriptive ethics approach	1. Sensitivity to the ethical dimensions of their clinical practice • What are the ethical issues that physical therapists routinely encounter? <sup>14(p703)</sup> • How does organizational context influence recognition and interpretation of ethical issues? <sup>14(p703)</sup> 2. Investigate the making of moral judgments • What type of moral reasoning do physical therapists use? <sup>14(p703)</sup> • What is the influence of sex, religion, or culture on moral judgments? 3. Uncover the influences on physical therapists' abilities and motivation to act morally • How do physical therapists view their role as a patient advocate? • What factors (organizational, contextual, policy) affect physical therapists' motivation for ethical action?
Carpenter and Richardson <sup>15</sup>	Review of ethics articles (2000–2007) 1. From 27 articles; increase in knowledge and research about unique ethical issues in physical therapy 2. Increased emphasis on moral agency and types of moral reasoning	1. How does the institutional setting affect the role of the physical therapist as a moral agent? 2. What are the cultural dimensions of ethical practice? 3. What are patients' perspectives on ethical practice?

The first issue raised by Poulis<sup>16</sup> concerns decision making about endpoints in physical therapy treatment in rehabilitative settings. Because a patient almost always can further improve with continuing physical therapy intervention, an appropriate endpoint for treatment may not be clear and the person responsible for deciding when the end of treatment occurs may not always be the physical therapist. Patients and other health care professionals may hold different definitions of end goals in rehabilitation.<sup>17,18</sup> Thus, decisions to commence or cease physical therapy treatment might be made by the physical therapist or by an alternative health care professional, or the decision might be made on the basis of funding constraints and opportunities.<sup>19,20</sup> Purtilo et al<sup>12(p41)</sup> defined these types of ethical issues as “locus of authority” problems. They include scenarios where a physical therapist, working within a multidisciplinary health care team, may not have the designated authority or moral agency to be able to achieve their discipline-

specific professional therapeutic goals and outcomes for the patient.<sup>17</sup>

Poulis<sup>16</sup> second ethical dimension of clinical practice concerns the often intimate and one-on-one interaction of physical therapy treatment, relying on touch, communication, advice, and at times, patient dependency. For example, patients with chronic illnesses,<sup>21,22</sup> athletes who depend on being injury free for competition,<sup>23</sup> and families who rely on ongoing management of their children with chronic conditions<sup>24</sup> form close and personal relationships with their treating physical therapist. The nature of these types of relationships means that physical therapists need to be skilled in integrating and balancing their own therapeutic goals and purposes with those of their patients.<sup>22,25</sup> This aspect of the patient/therapist relationship raises ethical issues concerned with recognizing and maintaining professional boundaries.<sup>26</sup>

The third ethical dimension of clinical physical therapist practice highlighted by Poulis<sup>27</sup> concerns the requirement for active participation of the patient and its impact on the patient/therapist relationship. Although trust is recognized as a crucial aspect of all health care practitioner relationships,<sup>28</sup> in physical therapy, a patient's trust must extend beyond accepting and believing in advice and treatment suggestions to a willingness to actively participate and collaborate to achieve the physical and functional goals set by his or her therapist.<sup>29</sup> This means that physical therapy treatment methods and decisions encompass ideas associated with leadership, motivation, and promoting change in health behavior.<sup>30,31</sup> These aspects of practice raise questions about associated ethical dimensions, such as:

- What processes and methods of informing or persuading patients to achieve or participate in a desired therapeutic outcome are ethically appropriate?

- What model of shared decision making is the most relevant for therapists working with patients?
- How do physical therapists incorporate ethical principles of trust, respect for autonomy, beneficence, and justice when setting goals with patients and formulating treatment strategies?

## Linking Ethical and Clinical Dimensions of Physical Therapist Practice

Two themes that arise from these descriptions and reviews of physical therapist practice and associated ethical dimensions are: connectedness and agency. In all aspects of physical therapist practice, there is a need to establish connections in the form of relationships with patients, patients' families, other health care professionals, and institutions and organizations that externally fund or in some way influence the course of physical therapy treatment. Kyler<sup>25</sup> described a relationship-centered approach to health care as one that captures the importance of interactions between people and social, political, economic, and environmental factors. In this article, we use the term "connectedness" to include this notion of interactive relationships and broaden it to extend to the web of associations and links between physical therapists and their discipline-based theoretical and practical approach to health care, their personal values, and the broader impact and influence of patients, health care colleagues, cultures, societies, institutions, and other health practices on physical therapist practice.

The theme of "agency" arises from the need for physical therapists to work collaboratively with their patients and others while maintaining separate knowledge, motivation, and courage to engage as autonomous professionals with the moral

aspects of their work.<sup>32</sup> Benner et al referred to agency as the "ability to act upon or influence a situation."<sup>33(p14)</sup> Agency to effect change in a patient or in others has links with notions of leadership,<sup>34</sup> mindfulness,<sup>35</sup> advocacy,<sup>32,36</sup> and expertise.<sup>37</sup> Agency requires a strong sense of self-awareness and an ability to be critically self-reflective.<sup>38</sup>

We have previously conceptualized these 2 themes that are derived from the clinical and ethical dimensions of physical therapist practice as moving between 2 sides of an ethical reasoning bridge.<sup>39</sup> On one side of the bridge, a physical therapist (or other health care professional) draws from the connections he or she makes with a patient's story to frame and recognize what seems to be ethically important. On the other side, the physical therapist draws from the meaning and philosophies found in the biomedical ethical principles and connects them with particular clinical contexts. Drawing from normative theory on one side and from patients' perspectives and individual constructions of meaning about practice on the other side requires physical therapists to have a clear sense of their role and capacity to respond and act in clinical situations. This movement between general knowledge and analytical thinking on the one hand and the challenges of a particular situation on the other has been described as "practical reasoning." Practical reasoning is done for a purpose, at a particular time, and in a particular situation.

This division of reasoning into practical, analytical, and theoretical forms derives originally from the work of Aristotle and has been reformulated by thinkers such as Dewey,<sup>40</sup> Schon,<sup>41</sup> and most recently, Sullivan.<sup>42</sup> Importantly, drawing upon knowledge and understanding from either side of the bridge assumes a level of practical authority or agency to connect ideas, understand relationships, and then im-

plement the decision. Moral agency in making ethical decisions, therefore, incorporates the ability to take from each side of the bridge, to make connections between ethical theory and practice, and to recognize the importance and influence of relationships built with patients, families, and other health care team members.

## An Applied Ethics Model: Active Engagement

The applied ethics model proposed in this article identifies an approach to ethical understanding and practice based on the themes of connectedness and agency in physical therapist practice. This model is grounded in the clinical work and education of physical therapists.<sup>1,2</sup> It draws upon and synthesizes different sources of literature, including the use of established biomedical ethical principles,<sup>43,44</sup> narrative theory,<sup>45-48</sup> and theories of sociology,<sup>13,49,50</sup> to decrease the gap between the ethical dimensions of physical therapist practice and physical therapy ethics knowledge and scholarship.

The model has 3 practical components: (1) to *listen* actively, (2) to *think* reflexively, and (3) to *reason* critically. These 3 components have previously been described in physical therapy and other health care ethics literature as strategies and steps for gathering information and perspectives, identifying ethical issues, and generating appropriate practical responses.<sup>12,51</sup> In our model, we have encapsulated these ideas into 3 practical steps that focus on the underlying skills, attitudes, and actions that are required to connect with people, systems, values, and structures and to build a sense of moral agency and purpose within physical therapists.

### Step 1: To Listen Actively

Physical therapists spend much of their time communicating with and listening to patients and colleagues

as a standard part of their work. Our contention in this first practical step is that ethical analysis in physical therapist practice begins with an active listening approach. Active listening has many layers. It requires a commitment to the importance of telling and listening to stories as a way of discussing ethical issues. It requires some attentiveness to and curiosity about the details of other people's stories. It also requires an awareness of how resources and their allocation affect peoples' stories about providing and receiving health care.

Associations between telling and listening to stories and ethical analysis have been made previously. Nelson<sup>52</sup> defined narrative ethics or the telling of stories as a way of approaching clinical ethics, not just as a description of the key features of a clinical case or scenario but also as a means of achieving a moral end in itself. In telling or relating a story about an experience, a person makes sense of his or her life and experiences.<sup>47,53-56</sup> For example, when a physical therapist tells a story about a clinical encounter, he or she implicitly or explicitly decides to portray himself or herself as a particular character with a sense of personal and moral agency. The therapist's way of telling the story also provides information about how he or she perceives and understands other characters in their clinical story.

Active listening in the ethics engagement model, therefore, is more than the exchange of information between the patient and therapist. It means listening closely to the patient's perspective and story and being actively engaged in making connections between the patient's circumstances, beliefs, values, and assumptions and the goals, values, resources, and actions of the therapist and of other people in the health care team. Both telling and listening

to stories also draws out the emotional aspects of health care practice.<sup>57,58</sup> These aspects encourage practitioners to reflect on how their emotional reactions to patients' stories and their own experiences can inform and facilitate reflection about ethical dimensions of practice.<sup>59</sup> Active listening, therefore, means being alert to what Guillemin and Gillam referred to as "ethically important moments."<sup>47(p7)</sup> These apparently mundane ethical experiences often encountered in ordinary clinical practice include moments of uncertainty about the right course of action, moments when there is a need to consider whether to speak up or not, moments when there is a recognition that a patient or a colleague needs support, and moments when there is a need to consider how and whether to persuade a patient to participate in an active treatment.

Guillemin and Gillam<sup>47</sup> used the label "sideways questions" to describe the types of questions that might facilitate active engagement with a story. Sideways questions go further than just relating the context, roles, and contributions in an abstract (formal case study, third-person) approach. The questions listed in Table 2 are based on these sideways questions. They aim to facilitate the consideration of broader aspects of physical therapists' and their patients' experiences to assist in identifying the ethically important dimensions of clinical treatment contexts.

### Step 2: To Think Reflexively

The second step in the active engagement framework is to think about one's own "physical therapy footprint" in the clinical scenario. *Reflexivity* and *critical reflection* are 2 related concepts that link to professional agency. Reflexivity means being aware of and paying attention to one's own perspective and voice in a situation. The idea of reflexivity

traditionally has been associated with paradigms of qualitative research<sup>60-62</sup> but is increasingly recognized as important in health care practice.<sup>13,50</sup> Guillemin and Gillam<sup>49</sup> described reflexivity in qualitative research as a process involving critical reflection on how the researcher constructs knowledge from the research process. According to Patton,<sup>62(p65)</sup> it reminds researchers to be attentive to and conscious of "the cultural, political, social, linguistic, and ideological origins" of their own perspective and voice, the perspectives and voices of those they interview, and the perspectives of those to whom the research is reported. Applied to ethical decision making, reflexivity provides a means to increase awareness of one's personal values, emotional reactions, and practices and how they might influence a patient's reactions and choices.<sup>35,63</sup>

To make connections with others and to recognize ethical dimensions in their work, physical therapists need to be self-aware, reflexive, and mindful of their own unique contribution and identity as physical therapists in their care of patients. Without this understanding of the nature of their own practice or epistemological basis,<sup>39,64</sup> their sense of agency and purpose and ways of connecting with others will be delivered in a professional vacuum. They will be less aware of how to make their connections with people and within institutions work toward achieving what is in the best interests of their patient. Within our model, the questions that we have developed to assist the reflective and reflexive process are listed in Table 2.

### Step 3: To Reason Critically

To reason critically means to examine assumptions or presuppositions about practice and connections between oneself and social con-

**Table 2.**  
Active Engagement Model: Steps and Questions

Steps	Facilitating Questions
Step 1: active listening	<ul style="list-style-type: none"> <li>● How has the patient and health care team member cast their story?</li> <li>● Within the story, how do they portray themselves?</li> <li>● Why are they telling the story in this way?</li> <li>● Whose voice in the story is dominant?</li> <li>● Whose voice in the story is not being heard?</li> <li>● How else might this story have been told?</li> <li>● What is ethically at stake in this story?</li> <li>● What are the ethically important moments in the story?</li> </ul>
Step 2: reflexive thinking	<ul style="list-style-type: none"> <li>● What goals and values do I, as the physical therapist, personally bring to a given treatment?</li> <li>● What goals and values are inherent within the physical therapy treatment that I offer?</li> <li>● What influence do my language and my treatment methods have on the patient and others?</li> <li>● How do others (patients, colleagues, managers) know what they know?</li> <li>● What shapes and has shaped their world view?</li> <li>● How do they perceive me and why?</li> <li>● How do I perceive them?</li> <li>● How do they make sense of what I give them?</li> <li>● What perspectives do they bring to the findings I offer?</li> </ul>
Step 3: critical reasoning	<p>Realm of patient and therapist relationship:</p> <ul style="list-style-type: none"> <li>● What values and goals do I bring to the therapeutic relationship?</li> <li>● How do my professional and personal values and goals differ from the patient's?</li> </ul> <p>Organizational realm:</p> <ul style="list-style-type: none"> <li>● What is my relationship with the health care organization?</li> <li>● How does this relationship influence the clinical encounter?</li> <li>● How do institutional systems and structures affect the patient's ability to receive treatment?</li> </ul> <p>Societal realm:</p> <ul style="list-style-type: none"> <li>● What are the health care structures, resources, and economic policies that influence the goals and provision of physical therapy?</li> </ul>

texts.<sup>65–67</sup> Critical reasoning has been described as a key dimension of clinical reasoning, incorporating 4 main attributes and abilities: (1) reflecting and interpreting a clinical situation; (2) understanding the clinical context, including cultural values and facts; (3) engaging in an interactive and constructive dialogue with patients, peers, and mentors; and (4) integrating the influence of time through past experience, present contexts, and future actions.<sup>68</sup> When applied as a component of the ethics engagement model, critical reasoning involves critical examination of the meaning and values of the 4 established biomedical ethical principles—beneficence, nonmaleficence, autonomy, and justice<sup>43</sup>—by asking questions about the meaning and scope of their relevance within the context of the clinical situation.<sup>44</sup> It also means being cognizant of the nature and effect of the patient/therapist relationship within broader realms of the institution and

the broader cultural and societal influences on the provision of health care.<sup>8</sup> The questions in Table 2 use Glaser's<sup>8</sup> categorization of different ethical realms to prompt a more critical examination of the micro and macro issues that affect clinical and ethical decision making.

### Applying the “Active Engagement” Model to Sally's Case

We use a single physical therapy case study involving a patient with chronic neuropathy, as told by the physical therapist, Sally, to illustrate how the active engagement framework might be used to link ethics knowledge in theory to ethics in practice (Figure). All names in this case study are pseudonyms. At the time that this case occurred, Sally had 3½ years of experience since graduation and worked as a junior physical therapist in a large metropolitan public hospital in a city in

Australia. She approached the primary author (C.M.D.) of this article to relate her personal clinical story. Sally then provided her informed consent to publish this version of her story. Specific ethical issues in Sally's story include deciding how to communicate truth to patients and their families about diagnoses and prognoses, continuing with treatment when there is no evidence to support its effectiveness, dealing with different health care professionals' views of what constitutes a patient's best interests, and working within hierarchical organizations. Sally's emotional responses expressed through the story include her feelings of frustration concerning professional relationships and conflicts between her values and those of the patient and her mother. In telling the story, Sally focuses on re-stating her beliefs about right actions and her justifications for those actions. When the active engagement model is used to analyze Sally's responses, these

The patient, Cara, was a 28-year-old woman with a history of systemic lupus erythematosus, a chronic inflammatory disease and chronic inflammatory demyelinating neuropathy. Previous admissions (lasting for 16 months) had involved insertion of a percutaneous endoscopic gastrostomy feeding tube and tracheostomy. Many specialist units (including neurologists and rheumatologists) had consulted on Cara's case, and no clear, agreed-upon diagnosis had been made to account for her varied, numerous, and severe symptoms.

By the time Cara was admitted to our hospital, she had 90-degree flexion contractures of both elbows, bilateral knee flexion contractures, and bilateral plantar-flexion contractures in her ankles, along with minimal trunk, head, and neck control. Cara was fully dependent for all nursing and personal hygiene care.

On admission, we (the treating team) had heard reports of how Cara's mother, Sonia, had been very difficult for the staff at the previous hospital to deal with. We heard (as part of the handover) about how Sonia had insisted that one unit at the previous hospital had been forbidden to be involved in Cara's care. We heard that Cara and Sonia were very difficult to deal with and were insisting on having family meetings all of the time and that they did not trust the medical staff.

Already I felt uneasy about the information that gets passed around about a patient and the family before anybody at our hospital had even met them. At what point does handing over information to ensure the care of the patient is adequate become gossip that is not necessarily helpful to anybody, and how do you point that out to your colleagues in an appropriate manner?

I was determined to get off to a good start with both Cara and her mother. During my assessment, it became quite clear to me that Cara's physical situation was disastrous, but I was optimistic that I could make a difference to her. As soon as Sonia met me, she told me that she did not trust any of the physicians, that nobody knew what they were talking about, and that all of the physicians at the previous hospital (especially the neurologists and rheumatologists) had misdiagnosed Cara's condition. Sonia told me that she had been doing some research on the Internet and had discovered that Cara had myopathy. Sonia was furious that Cara had been diagnosed with Guillain-Barré syndrome and neuropathy and insisted that myopathy was Cara's main problem. Sonia further told me that she had found information on the American Medical Association Web site that the main or only treatment for myopathy was physical therapy.

I explained to Sonia that there was a limited role for physical therapy in providing return of muscle function. I tried to give Sonia clear information about Cara's condition from a physical point of view. I explained that until the nerves could transmit the signal better, we could only strengthen the muscle fibers that were

innervated, of which there were very few. I went into detail about the treatments I was trying and the rationale behind them.

I explained that physical therapy, as a profession, really does not have any good peer-reviewed evidence for the treatment techniques that we were trying. I also made the point that the Internet is an unregulated source of information and that Sonia should not take for granted information that was accessed from the Internet. I felt good at the end of our conversation because Sonia seemed to take on board my key points. Sonia was pleasant to deal with, and it was clear to me that she only had her daughter's best interests in mind.

I consulted orthopedic and neurological physical therapists about the best way to try to treat Cara's contractures. I grew frustrated because I was trying various treatments, few of which Cara could tolerate, and even fewer (ie, none) of which seemed to make a difference. I explained to both Cara and her mother that we needed to start to change the focus of treatment and that we would wind back the tilt table to only 3 times a week. I kept requesting that we hold a family meeting so that Cara and her family, particularly Sonia, could hear from several sources rather than just me about Cara's poor physical prognosis. I also felt in a difficult situation in the physical therapy department because a physical therapist who was senior to me had covered my ward once or twice and had recommenced some treatments I had ceased.

One afternoon, I received a page saying that I was being verbally attacked by Sonia in front of the whole ward round and that I should probably come up and defend myself. I felt upset that a layperson would question my professionalism in front of all of my colleagues. All of my colleagues (nursing, medical, and physical therapy staff) were very supportive after that ward round, but I would have loved to tell them that I would rather they were truthful to Cara and Sonia the whole time rather than nice to me when it all boiled over. In summary, I believe it is important to always try to communicate the truth to the patient and family, no matter how much they do not want to hear it—I believe it is our professional responsibility. I believe it is unethical to continue to provide treatments that are not working. I do not like feeling undermined, and I do not like feeling betrayed. If somebody has a problem with me, I would rather he or she told me in person without broadcasting it to the world while I am unaware of it. It is important to back your clinical judgment and have faith and trust in yourself. The health care system needs some serious revamping. Health care workers should never allow the patient and family to dictate the interaction—to be involved yes, but never to dictate. If I had the same situation again, I would do the same thing because ultimately I do not believe it helps anybody to hide the truth about a situation. Better frameworks to deal with emotional and mental and ethical stresses should be taught throughout the life span.

### Figure.

Sally's story.

**Table 3.**  
Questions For and Answers From Sally

Questions for Sally	Answers
1. How has the story been cast?	The focus of my story is on my analysis of my reactions and responses to the clinical scenario.
2. How has Sally, in telling the story, portrayed herself?	I cast myself as having good therapeutic intentions, including being determined to bring about a change where others had clearly had difficulty in the past.
3. Why is Sally telling the story in this way?	I wanted to justify my position and decisions about the treatment and the conflict surrounding the treatment.
4. Whose voice in the story is dominant?	My voice is dominant.
5. Whose voice in the story is not being heard?	Cara's voice is not present in the telling of this story. Sonia's voice, as the mother, is overbearing and strident. Other health care colleagues are cast as passive players in the story.
6. How else might this story have been told?	The story could have been told from the perspective of Cara, her mother, or other members of the treating team.
7. What is ethically at stake in this story?	How to define futility in long-term rehabilitation care. How to negotiate differences in values and beliefs about health care among patients, patients' family members, and physical therapists. Defining the scope and limitations of professional autonomy. The influence of both collegiality and diversity in professional health care approaches on patient outcomes. The rights of competent adult patients to decide their health care.
8. What are the ethically important moments?	When Sally first wondered about the information conveyed about Cara and her mother at handover. When Sally felt uncomfortable about how much information she should convey to Cara and her mother. When Sally reflected on the futility of the treatment. When Sally felt she was not supported by her colleagues.

ethical issues are broadened to include a richer and broader range of considerations to provide insight and guidance for Sally in this situation and for future similar clinical scenarios.

### Step 1: To Listen Actively

Step 1 of the active engagement model requires active listening and active engagement with Sally's story. Table 3 lists the questions and Sally's responses to this first step.

### Step 2: To Think Reflexively

The aims of the reflexive questions in step 2 are to expand the perspectives and understanding of the clinical situation and to provide opportunities to engage with other people's possible stories rather than focus only on presenting a coherent and justified view of one's own actions. When Sally responded to the reflexive and reflective questions in step 2 of the framework, she began to consider the goals and values that she

had brought to the encounter, not just as a means of justifying her decision or her rationale for refusing treatment but also as a way of examining how they intersect with and influence the goals and values held by the patient, "Cara," and her mother, "Sonia." Sally stated that her overriding goals at the time were to "communicate clear and accurate information regarding physical capacity and prognosis" and to ensure that her patient "should be in a position to make an informed decision." Sally did not believe that "laypeople using the Internet" was a source of accurate information, comparable with analysis of peer-reviewed literature. On further reflection about how these values intersected with those of her patient, Sally stated:

My language and treatment methods (as a junior and developing clinician) were very self-focused. That would certainly influence both Sonia's and Cara's responses to me if they per-

ceived that I was not as interested in their perspectives as I was my own. . . . I think that I could have considered that nursing and medical staff and my colleagues knew what they knew from clinical experience (in the main); however, none of these people (nor I) were particularly good at communicating how we knew what we knew and sharing information or discussing these perspectives openly.

Sally also used the reflexive questions to start to analyze, from a critical perspective, how others might have perceived her reactions, responses, and views.

### Step 3: To Critically Reason

In this step, Sally considered and evaluated the meaning of the biomedical ethical principles and how they applied to her story. For example, when considering the most beneficial treatment for Cara, Sally questioned the meaning of beneficence for someone in Cara's situation. At the time, Sally believed that the most

appropriate treatment for Cara was one that had demonstrated efficacy, that is, be defined only with reference to published evidence. Sally was also prompted to consider the impact of her role as an employee of a large metropolitan hospital. Her reflections highlight the duties she owed to her physical therapy department; relevant policies and procedures about patient care, and the existing hierarchies within the institution's professional team:

My relationship with the health care organization was developing and in its infancy. I perhaps did not speak up as early or as much as perhaps was required (for a series of reasons), including a perception that more senior colleagues knew better, and . . . I was somewhat intimidated by the respiratory consultants and more broadly by the hierarchy of the hospital system.

### Implications for Practice and Education

Using the active engagement framework opens up different questions and considerations. In Sally's story, it leads to thinking about:

1. The goals of physical therapy in chronic and degenerative conditions.
2. The "sandwich" role sometimes played by physical therapists in providing rehabilitative treatment (ie, sandwiched between a need to meet the patient's needs as recognized by the patient and needing to meet the goals of other members of the health team). Varcoe and Rodney,<sup>69</sup> writing for nurses, labeled this "constrained moral agency," where constraints or barriers to acting in what they might see as the patient's best interests are formed by interests of the others involved in their care and health care decision making. For physical therapists, Carpenter<sup>70</sup> used the term "moral distress" to describe the experience

of being unable to achieve the desired outcomes for clients within complex health care environments.

3. The idea of professional boundaries and ideals of practice. How much treatment should physical therapists offer when there are no strict boundaries around rehabilitation treatment? Who should decide the scope and nature of physical therapy services for these patients—the patient, the family, colleagues?
4. How to optimize communication among health care colleagues within large public hospitals. How can physical therapists enhance that communication?

In Sally's words, after telling and reflecting upon this story:

I have an enhanced perspective of the health care system and the influences and perspectives of various bodies (including system, organization, team, family, other staff members, and the patient) on the therapeutic interaction, including relationships between myself and Cara (and Sonia). Working through the framework allowed me to realize that there are multiple strategies that I can incorporate and multiple ways of dealing with ethical issues as they arise. Ideally, this would equip clinicians with the tools to more comfortably work with these "ethically challenging or important moments" and be less intimidated by them and to see them as an opportunity to inform their clinical or therapeutic interaction and development, and not least to improve their ability to deliver optimal patient care in the setting within which they work.

The outcome of telling and thinking about Sally's story does not immediately present a solution in terms of ethical actions. The practical outcome is not limited to using ethical reasoning to justify the application of biomedical ethical principles. In-

stead, it facilitates more active engagement with ethical issues by acknowledging and questioning values, emotions, guiding ethical principles, and systems and procedures that affect provision of care. The end result of using the active engagement model is to generate a bigger list of smaller or more everyday ethical issues that arise in clinical practice. Using the tenets of narrative reasoning, it involves the generation of hypotheses related to the particular details of a situation or person's experience.<sup>33</sup> The model also works toward integrating both normative (philosophical) and empirical (facts and experiences) dimensions of ethics in clinical practice.<sup>14</sup>

Heightened awareness of "ethically important moments"<sup>49</sup> means that the next time Sally finds herself in the position of dealing with a patient whose values about health and whose interpretations of benefit differ from her own, she may remember what she previously learned by the telling and reflecting on what was important in this story. It may lead her to raise the issue earlier within her own department—that is, how to deal with a patient who demands treatment that is not considered to be beneficial and to seek opinions from other physical therapists. Sally may speak earlier to the consultants and physicians involved in the patient's care to more explicitly establish roles and expectations within the team. Sally may think about the limits of physical therapy treatment and review the goals of treatment to be more realistic in similar treatment situations. In addition, as she becomes a more experienced clinician, this method of active engagement will enhance her ability to consider the perspectives of the patient, the family, and the treating team, as well as to be cognizant of the influence of the broader hospital system. Sally may seek support from

colleagues much earlier and be more comfortable discussing and sharing ethically important moments with others.

## Conclusion

Emerging literature in physical therapy<sup>13,39,71</sup> and in health care more generally<sup>8,11,16,53,72,73</sup> suggests gaps between knowledge of ethical theory and its implementation in practice. These considerations point to a need for a more applied approach to ethics in clinical practice, that is, one that draws from everyday clinical situations, including identifying practical opportunities for and constraints to acting ethically.

In this article, we have proposed a model of applied ethics based on current ethics scholarship and the distinctive features of physical therapy clinical practice. In order to refine this model, more research is needed about the nature and scope of ethical issues in physical therapist practice and how physical therapists respond as moral agents in their everyday practice. Our model posits that telling, listening to, and questioning stories about clinical practice experiences provides a first step in illuminating both obvious and hidden ethical perspectives in physical therapy work. It provides a link between ethical theories and knowledge and physical therapists' experiences of ethics in practice. Reflecting on stories reflexively and critically adds a further dimension to understanding ethical issues. Importantly, it provides a method for physical therapists to learn the processes necessary for developing moral agency within their day-to-day practice.

Dr Delany, Dr Edwards, and Dr Jensen provided concept/idea/project design. Dr Delany and Dr Skinner provided data collection and analysis. Dr Delany provided project management. All authors provided writing

and consultation (including review of manuscript before submission).

This article was submitted November 14, 2009, and was accepted March 21, 2010.

DOI: 10.2522/ptj.20090379

## References

- Higgs J, Refshauge K, Ellis E. Portrait of the physiotherapy profession. *J Interprof Care*. 2001;15:79-89.
- Higgs J, Smith M, Webb G, Skinner M, eds. *Contexts of Physiotherapy Practice*. Sydney, Australia: Elsevier; 2008.
- Carpenter C. The evolving culture of physiotherapy. *Physiother Can*. 1996;48:11-15.
- Linker B. The business of ethics: gender, medicine, and the professional codification of the American Physiotherapy Association, 1918-1935. *J Hist Med Allied Sci*. 2005;60:320-354.
- Stachura K. Professional dilemmas facing physiotherapists. *Physiotherapy*. 1994;80:357-360.
- Clawson AL. The relationship between clinical decision making and ethical decision making. *Physiotherapy*. 1994;80:10-14.
- Anderson L, Ellis E. Ethics, practice regulation and physiotherapy. In: Higgs J, Smith M, Webb G, et al, eds. *Contexts of Physiotherapy Practice*. Sydney, Australia: Elsevier; 2009:177-188.
- Glaser J. Three realms of ethics: an integrating map of ethics for the future. In: Purtilo RB, Jensen GM, Royeen CB, eds. *Educating for Moral Action: A Sourcebook in Health and Rehabilitation Ethics*. Philadelphia, PA: FA Davis Co; 2005:169-184.
- Delany CM. Respecting patient autonomy and obtaining their informed consent: ethical theory—missing in action. *Physiotherapy*. 2005;91:197-203.
- Delany CM. In private practice, informed consent is interpreted as providing explanations rather than offering choices: a qualitative study. *Aust J Physiother*. 2007;53:171-177.
- Edwards I, Braunack-Mayer A, Jones M. Ethical reasoning as a clinical-reasoning strategy in physiotherapy. *Physiotherapy*. 2005;91:229-236.
- Purtilo RB, Jensen GM, Royeen CB, eds. *Educating for Moral Action: A Sourcebook in Health and Rehabilitation Ethics*. Philadelphia, PA: FA Davis Co; 2005.
- Jensen GM. Mindfulness: applications for teaching and learning in ethics education. In: Purtilo RB, Jensen GM, Royeen CB, eds. *Educating for Moral Action: A Sourcebook in Health and Rehabilitation Ethics*. Philadelphia, PA: FA Davis Co; 2005:191-202.
- Swisher LL. A retrospective analysis of ethics knowledge in physical therapy (1970-2000). *Phys Ther*. 2002;82:692-706.
- Carpenter C, Richardson B. Ethics knowledge in physical therapy: a narrative review of the literature since 2000. *Phys Ther Rev*. 2008;13:366-374.
- Poulis I. Bioethics and physiotherapy. *J Med Ethics*. 2007;33:435-436.
- Flett PJ, Stoffell BF. Ethical issues in paediatric rehabilitation. *J Paediatr Child Health*. 2003;39:219-223.
- Gibson BE, Darrach J, Cameron D, et al. Revisiting therapy assumptions in children's rehabilitation: clinical and research implications. *Disabil Rehabil*. 2009;31:1446-1453.
- Purtilo RB. Managed care: ethical issues for the rehabilitation professions. *Trends Health Care Law Ethics*. 1995;10(1-2):105-108, 118.
- Thomasma DC. The ethics of managed care: challenges to the principles of relationship-centered care. *J Allied Health*. 1996;25:233-246.
- Baker J, Stiller K. Chronic illness: a view from the other side. *Aust J Physiother*. 2006;52:155-156.
- Latimer J, Maher C, Refshauge K. The attitudes and beliefs of physiotherapy students to chronic back pain. *Clin J Pain*. 2004;20:45-50.
- McKenna J, Delaney H, Phillips S. Physiotherapists' lived experience of rehabilitating elite athletes. *Phys Ther Sport*. 2002;3:66-78.
- Carnevale FA, Alexander E, Davis M, et al. Daily living with distress and enrichment: the moral experience of families with ventilator-assisted children at home. *Pediatrics*. 2006;117:e48-e60.
- Kyler P. The ethics of client-centered care models. In: Purtilo RB, Jensen GM, Royeen CB, eds. *Educating for Moral Action: A Sourcebook in Health and Rehabilitation Ethics*. Philadelphia, PA: FA Davis Co; 2005:159-167.
- Cooper I, Jenkins S. Sexual boundaries between physiotherapists and patients are not perceived clearly: an observational study. *Aust J Physiother*. 2008;54:275-279.
- Poulis I. The end of physiotherapy. *Aust J Physiother*. 2007;53:71-72.
- O'Neill O. *Autonomy and Trust in Bioethics*. Cambridge, United Kingdom: Cambridge University Press; 2004.
- Parry RH. Communication during goal-setting in physiotherapy treatment sessions. *Clin Rehabil*. 2004;18:668-682.
- Bass BM, Steidlmeier P. Ethics, character, and authentic transformational leadership behaviour. *The Leadership Quarterly*. 1999;10:181-217.
- Buchanan D. Moral reasoning as a model for health promotion. *Soc Sci Med*. 2006;63:2715-2726.
- Davis C. Educating adult health professionals for moral action: in search of moral courage. In: Purtilo RB, Jensen GM, Royeen CB, eds. *Educating for Moral Action: A Sourcebook in Health and Rehabilitation Ethics*. Philadelphia, PA: FA Davis Co; 2005:215-224.
- Benner P, Hooper-Kyriakidis P, Stannard D. *Clinical Wisdom and Interventions in Critical Care: A Thinking-in-Action Approach*. Philadelphia, PA: WB Saunders Co; 1999.

- 34 Chervenak FA, McCullough LB. The moral foundation of medical leadership: the professional virtues of the physician as fiduciary of the patient. *Am J Obstet Gynecol*. 2001;184:875-880.
- 35 Jensen GM, Richert A. Reflections on the teaching of ethics in physical therapist education: integrating cases, theory and learning. *J Phys Ther Educ*. 2005;19:78-85.
- 36 Hewitt J. A critical review of the arguments debating the role of the nurse advocate. *J Adv Nurs*. 2002;37:439-445.
- 37 Jensen GM, Gwyer J, Shepard KF. Expert practice in physical therapy. *Phys Ther*. 2000;80:28-43.
- 38 Delany CM, Watkin D. A study of critical reflection in health professional education: "learning where others are coming from." *Adv Health Sci Educ Theory Pract*. 2009;14:411-429.
- 39 Edwards I, Delany CM. Ethical reasoning. In: Higgs J, Jones M, Loftus S, Christensen N, eds. *Clinical Reasoning in the Health Professions*. 3rd ed. Boston, MA: Elsevier; 2008:279-289.
- 40 Dewey J. *How We Think: A Restatement of the Relation of Reflective Thinking to the Educative Process*. Boston, MA: DC Heath & Co; 1933.
- 41 Schon D. *Educating the Beginning Practitioner*. San Francisco, CA: Jossey-Bass; 1987.
- 42 Sullivan W. *Work and Integrity: The Crisis and Promise of Professionalism in America*. San Francisco, CA: Jossey-Bass; 2005.
- 43 Beauchamp T, Childress J. *Principles of Biomedical Ethics*. 5th ed. Oxford, United Kingdom: Oxford University Press; 2001.
- 44 Gillon R. Medical ethics: four principles plus attention to scope. *BMJ*. 1994;909:184-188.
- 45 Adams TE. A review of narrative ethics. *Qual Inquiry*. 2008;14:175-194.
- 46 Brody H. *Stories of Sickness*. New York, NY: Oxford University Press; 2003.
- 47 Guillemin M, Gillam L. *Telling Moments: Everyday Ethics in Health Care*. Melbourne, Australia: IP Communications; 2006.
- 48 Kleinman A. *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger*. Oxford, United Kingdom: Oxford University Press; 2006.
- 49 Guillemin M, Gillam L. Ethics, reflexivity, and "ethically important moments" in research. *Qual Enquiry*. 2004;10:261-280.
- 50 Taylor C, White S. *Practicing Reflexivity in Health and Welfare*. Buckingham, United Kingdom: Open University Press; 2000.
- 51 Kerridge I, Lowe M, McPhee J. *Ethics and Law for the Health Professions*. 2nd ed. Sydney, Australia: Federation Press; 2005.
- 52 Nelson H. Introduction. In: Nelson H, ed. *Stories and Their Limits: Narrative Approaches to Bioethics*. New York, NY: Routledge; 1997.
- 53 Guillemin M, Gillam L. Ethical mindfulness: narrative analysis and everyday ethics in health care. *Adv Med Sociol*. 2008;9:159-180.
- 54 Nelson HL. Context: backward, sideways and forward. In: Charon R, Montello M, eds. *Stories Matter: The Role of Narrative in Medical Ethics*. New York, NY: Routledge; 2002.
- 55 Nelson HL. Moral teachings from unexpected quarters: lessons for bioethics from the social sciences and managed care. *Hastings Cent Rep*. 2000 30:12-17.
- 56 Greenhalgh T. *What Seems to Be the Trouble: Stories in Illness and Healthcare*. Oxford, United Kingdom: Radcliffe Publishing; 2006.
- 57 Goldie P. Narrative and perspective: values and appropriate emotions. In: Hatzi-moysis A, ed. *Philosophy and the Emotions*. Cambridge, United Kingdom: Cambridge University Press; 2003.
- 58 Shapiro J, Rucker L, Boker J, Lie D. Point-of-view writing: a method for increasing medical students' empathy, identification and expression of emotion, and insight. *Educ Health (Abingdon)*. 2006;19:96-105.
- 59 Lemonidou C, Papatthanassoglou E, Giannakopoulou M, et al. Moral professional personhood: ethical reflections during initial clinical encounters in nursing education. *Nurs Ethics*. 2004;11:122-137.
- 60 Barry C, Britten N, Barber N, et al. Using reflexivity to optimise teamwork in qualitative research. *Qual Health Res*. 1999;9:26-44.
- 61 Hansen E. *Successful Qualitative Health Research*. Sydney, Australia: Allen & Unwin; 2006.
- 62 Patton M. *Qualitative Research and Evaluation Methods*. 3rd ed. Thousand Oaks, California: Sage Publications; 2002.
- 63 Wessel J, Larin H. Change in reflections of physiotherapy over time in clinical placements. *Learn Health Soc Care*. 2006;5:119-132.
- 64 Richardson B, Higgs J, Dahlgren M. Recognising practice epistemology in the health professions. In: Higgs J, Richardson B, Dahlgren M, eds. *Developing Practice Knowledge for Health Professionals*. Edinburgh, Scotland: Butterworth Heinemann; 2004:1-14.
- 65 Brookfield S. *Becoming a Critically Reflective Teacher*. San Francisco, CA: Jossey-Bass; 1995.
- 66 Sullivan W. *Work and Integrity: The Crisis and Promise of Professionalism in America*. San Francisco, CA: Jossey-Bass; 2005.
- 67 Mezirow J. *Transformative Dimensions of Adult Learning*. San Francisco, CA: Jossey Bass; 1991.
- 68 Christensen N, Jones M, Higgs J, Edwards I. Dimensions of clinical reasoning capability. In: Higgs J, Jones M, Loftus S, Christensen N, eds. *Clinical Reasoning in the Health Professions*. Amsterdam, the Netherlands: Butterworth Heinemann 2008:101-110.
- 69 Varcoe C, Rodney P. Constrained agency: the social structure of nurses' work. In: Bolaria B, Dickinson H, eds. *Health, Illness and Health Care in Canada*. Toronto, Ontario, Canada: Nelson; 2002.
- 70 Carpenter C. Moral distress in physical therapy practice. *Physiother Theory Pract*. 2010;26:69-78.
- 71 Mstrom E. Teaching and learning about the ethical and human dimensions of care in clinical education: exploring student and clinical instructor experiences in physical therapy. In: Purtilo RB, Jensen GM, Royeen CB, eds. *Educating for Moral Action: A Sourcebook in Health and Rehabilitation Ethics*. Philadelphia, PA: FA Davis Co; 2005:265-284.
- 72 Jensen GM, Paschal K. Habits of mind: student transition toward virtuous practice. *J Phys Ther Educ*. 2000;14:42-47.
- 73 Lucius-Hoene G. Illness narratives and narrative medicine. *Rehabilitation (Stuttg)*. 2008;47:90-97.

### Invited Commentary

E. Lynne Geddes

Applying ethical reasoning within clinical practice is crucial to holistic patient care. In their article, Delany et al<sup>1</sup> use insights from 2 retrospective analyses of physical therapy ethics knowledge<sup>2,3</sup> as the springboard for their applied model of physical

therapy ethics. Both Swisher<sup>2</sup> and Carpenter and Richardson<sup>3</sup> identified gaps that exist between ethics knowledge and clinical practice. Hence, Delany et al<sup>1</sup> propose a model to close this gap. The article concludes by applying the model to

a clinical scenario to assist the reader in exploring its application.

This discussion is timely within the profession. As a registered physical therapist in Ontario, Canada, my College of Physiotherapists of Ontario<sup>4,5</sup>