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## ETHICS OF TOUCH-AXIOLOGICAL MODEL OF THERAPEUTIC RELATION IN PHYSIOTHERAPY<sup>1</sup>

Keywords: ethics of touch, ethics of physiotherapy, therapeutic relation in physiotherapy, body, care

Physiotherapy is a crucial part of rehabilitation and its main objective is to develop, maintain and restore maximum motor and functional abilities in patients of various age and with different medical conditions. Physiotherapists treat dysfunctions of the neuromuscular, musculoskeletal, cardiovascular

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<sup>1</sup> This paper is the result of the research project no 2016/21/B/HS1/01824 entitled “Physiotherapist’s Ethics. Touch, Corporeality, Intimacy”, which was funded by the National Science Centre, Poland.

and respiratory systems. They have competence to examine, assess, carry out functional diagnosis, provide prognosis, plan treatment and re-assess patients for the needs of the conducted therapeutic process. Ethics of the physiotherapist profession is a relatively new field of bioethical considerations. National and international codes of physiotherapists' professional ethics formulate ethical standards of professional conduct by referring to patients' rights and basic bioethical principles and values common to all medical professions. The increasing number of bioethical works concerning philosophical and ethical aspects of human corporality in medicine hardly ever mention moral, emotional or psychological problems connected with physiotherapists' use of touch as a diagnostic and therapeutic tool. There is also lack of discussion on ethical values particularly relevant in the context of physiotherapeutic intervention and work with the body.

### Ethics in physiotherapy

The profession of a physiotherapist became recognized in many countries as an autonomous vocation in the second half of the twentieth century (in Poland only in 2015). This led to a discussion among therapists regarding ethical principles of the profession and creation of appropriate ethical regulations at both national and international levels (American Physical Therapy Association [APTA], 2004, 2009; World Confederation for Physical Therapy [WCPT], 2011; Chartered Society of Physiotherapy [CSP], 2011, 2012). These documents are quite general in nature since they take into account five areas of physiotherapists' work: practice in patient management, consultation, education, research and administration. Some domestic codes of ethics, for instance the Code of Professional Ethics approved by the National Chamber of Physiotherapists in Poland (Krajowa Izba Fizjoterapeutów, 2016), refer to the values relevant to various health professions without paying sufficient attention to the moral specificity of physiotherapist's work and the moral problems of rehabilitation and physiotherapy.

The need for research on physiotherapy unique moral aspects was noticed quite early (Purtilo, 1974). The literature on physiotherapist – patient relationship draws special attention to the interpretation of fundamental bioethical values such as autonomy, dignity, beneficence, non-maleficence, justice, confidentiality and truthfulness. The issues discussed include the

principles of obtaining informed consent, respect for individuals and their privacy, the impact of therapy on patient's quality of life, prioritization and selection of therapy within limited financial resources, lack of justification for continuing therapy only for mental support, importance of patient's motivation and cooperation, resolving patient-family conflicts related to setting rehabilitation, cooperation and division of responsibilities in a therapeutic team, research on ethical principles in physiotherapy, relationship between physiotherapist's autonomy and responsibility towards the patient, a therapist and a researcher – conflict roles solving (Guccione, 1980; Triezenberg, 1996; Swisher, 2002; Finch, Geddes, Larin, 2005; Sandstrom, 2006).

There is limited literature (Gabard, Martin, 2011, pp. 163–178; Doherty, Purtilo, 2016, pp. 71–100) that would comprehensively consider ethical problems of physiotherapy and refer to various theoretical models of bioethics and moral values which are relevant to physiotherapeutic intervention. The current state of knowledge in the field of ethics in physiotherapy is rightly expressed by the following statement: “We need the help of bioethicists who address issues in physiotherapy and of physiotherapists who understand better ethical problems of clinical practice” (Poulis, 2007, p. 436). Research works analyzing the process of ethical decision making by health professionals and providing practical examples of ethical principles implementation in clinical practice are highly regarded (Benjamin, Sohnen-Moe, 2014, pp. 19–23; Doherty, Purtilo, 2016, pp. 105–120). It proves the importance of ethical issues in physiotherapist's practice and shows the need for establishing better standards of ethics education.

Are there any justified moral grounds for distinguishing physiotherapist-patient relation from other therapeutic relationships in medicine? It is worth stressing some characteristics of the physiotherapist-patient contact which give rise to specific moral problems in physiotherapy. They include:

- lack of a specific final point in the rehabilitation process,
- need to stimulate patient's activity,
- cooperation with the patient's family to determine rehabilitation objectives and methods,
- subjective evaluation of the quality of life,
- long-term and close personal contact with the patient which helps to achieve the set objectives,
- psychosocial meaning of touch,
- non-verbal ways of communication with a patient.

The last three aspects of physiotherapist-patient relationship are the basis for creating the axiological model of therapeutic relation in physiotherapy.

### The importance of touch in physiotherapist's work

One of the important ethical aspects concerns physiotherapist's intimate relationship with their patient based on trust, touch, communication and patient's dependency (Poulis, 2007; Delany, Edwards, Jensen, Skinner, 2010). Physiotherapist's work with patient's body requires entering another person's intimate space. Touch has both therapeutic and psychosocial significance. What is important for the therapeutic relationship is patient's attitude to their body, the significance of physical contact in their particular culture as well as their positive or traumatic experiences. "Body memory" registers not only tactile information, but also emotional states which can occur during treatment. Through touch physiotherapist can give support and acceptance by building proper and effective therapeutic relationship. Touch may play the role of informal communication (Benjamin, Sohn-Moe, 2014, pp. 115–119, 308–312; Dadura, Wójcik, Gajewski, 2013; Rusin, 2013, pp. 164–165).

Doctors or nurses are, indeed, entitled to have access to personal space and body of other people, however, it is the notion of "work with body" that is crucial for physiotherapists. Touching, communicating, establishing and staying in contact are particularly important. It is all connected with carnality, empathy and feeling in the bodies (not only in hands) of a patient and therapist. Both sides of the established contact and relationship being created are important in this process. From the patient's perspective we differentiate the following aspects of this process:

1. What other parts of physiotherapist's body touch me (for instance, when learning to walk a patient with hemiplegia sometimes needs to be supported on the affected side with physiotherapist's whole body; physiotherapist somehow initiates individual parts of the movement with their body or leads the whole movement).
2. Which parts of my body are being touched (examination of inferior body parts includes examination of pelvis, buttocks or intimate areas like pubic symphysis or pelvic floor muscles, for example in pregnant women).

3. How long touch lasts (how sensitive physiotherapist is and if they are able to read non-verbal body signals sent by patient who does not report discomfort or suffering).
4. What pressure was applied (some treatments, especially in sports medicine, are very painful and aggressive).
5. Is there movement after establishing contact (if the undertaken activity includes exceptional suffering, does patient stand a chance to succeed and obtain movement they are “fighting for”).
6. Is there anybody else present and, if yes, who it is (working in a common room where everybody is dressed may be not a big challenge, but undergoing physiotherapy in a ward where everybody is being respectively exposed and might be undressed, for example in the intensive care ward, is an extremely difficult situation). In other words, do I get undressed for examination or treatment in the presence of other patients or medicals.
7. Relationship that takes place between me and the person who touches me (do I feel comfortable with a person who constantly violates my boundaries, also intimate; do I like them or simply depend on them).
8. Circumstances in which touch takes place (is the treatment place screened; can patient’s intimacy be preserved) (Benjamin, Sohnen-Moe, 2014).

This particular dialog requires not only listening and communication abilities, but also development of a specific form of listening which is active listening through touch. What is exceptional in this profession is the fact that physiotherapist listens not only with hands, but frequently with their whole body, utilizing this ability in direct work with patient’s body (diagnosis, treatment, safeguarding, and sometimes even support). In certain clinical situations (in acute neurology wards) it may happen that the bodies of patient and physiotherapist are almost in constant contact for some period of time. Work with a reliant and fully-dependent patient is usually based on constant physical contact. Despite being different in the sense of its aim and way of application, it is still physical contact. If needed, for instance a lonely person in their home, and patient requires pre-therapy preparation, physiotherapist changes them or dresses and subsequently transfers to a wheelchair and takes to the treatment place. Even when patient does not cooperate, physiotherapist carries it all out with the use of their body and

appropriate technique. The bigger the paresis or lack of cooperation, the bigger the support based on physical contact with physiotherapist's body is. Only then, the therapy (medical intervention) time commences which also takes place through manual activity focused 'only' on hands. Subsequent stages connected with return to bed happen similarly to the initial phase. One should not forget about special situations like the need of support through touch/pat/hug or change of nappy pants.

Touch is an integral and indispensable part of physiotherapist profession. Thus, it seems to play a key role and the ability to apply proper touch is one of the main competences differentiating this profession from other medical occupations. Few studies underline that mastering this ability is related to practical experience rather than formal training (Roger et al., 2002; Bjorbækmo, Mengshoel, 2016). Therefore, it is claimed that at the beginner stage of this profession, work with the body is often ambivalent and may violate the norms of bodywork, especially with respect to touch. Young professionals who want to examine, diagnose and cure in the first place, focus mainly on the part of the body which is directly under their activity. Patients themselves constitute as if background which is quite difficult for them to notice. They pay little attention to how patient receives and interprets touch. Unfortunately, similar threat exists in case of long-term internships or workplace where physiotherapist does not realize their full professional potential (Roger et al., 2002).

A limited number of studies emphasize the fact that how touch is applied in the process of physiotherapy depends in individual skills of a therapist (Bjorbækmo, Mengshoel, 2016; Hiller, 2017). They include both technical skills as well as conscious understanding of what is happening between them and patients at different stages of examination or treatment and during further direct physical contact. Since physiotherapy is becoming more and more complex, there is also a growing need for deeper understanding of how physiotherapists behave in real situations and what kind of touch they use in their daily routine activities (Bjorbækmo, Mengshoel, 2016).

The existing studies on touch in physiotherapy have attempted to describe and categorize types and goals of touch and have identified it as a crucial element of professional practice. Very few researchers decide to categorize types of touch and its intentions in detail. Therefore, in healthcare services one can encounter such terms as instrumental, expressive, caring

or diagnostic touch. The broadest approach is offered by the following classification:

#### THERAPEUTIC TOUCH

- Diagnostic – touch used to examine patient’s body and collect key medical information from patient’s body to enable diagnosis.
- Interventional – healing (therapeutic intervention has been classified as task-oriented touch used to provide direct, manual treatment such as massage or joint mobilization).
- Assisting – supporting selected movement fragments (touch used to provide physical assistance to patient. Examples of this type of touch include managing specific movement such as range of motion active assistant or helping patient in transfer).
- Informative – touch used to obtain information, supporting diagnostic activities or informing about symptoms occurring during therapy.

#### NON-THERAPEUTIC TOUCH

- Caring – contact aiming to provide consolation, encouragement, empathy or support to patient.
- Relationship building – shaking hands to say hello and goodbye. Security building / providing – form of touch to give patient a sense of security or confidence, independent of the fact if it was physically necessary.
- Preparatory – non-therapeutic form of touch, preparing patient for therapy (for example, dressing patient or putting their shoes on) (Roger et al., 2002).

Personal experiences of people with disabilities as well as bioethical reflection on cognitive, emotional, psychological, existential and axiological problems a disabled person has to face are very important for physiotherapeutic practice and therapeutic relationship (Przyłuska-Fiszler, 2003; Kowalik, 2007, pp. 72–87). A special role should be assigned to the reflection on the moral consequences of violating emotional, intellectual, sexual and energy boundaries in physiotherapist practice. Ben Benjamin and Cherie Sohnen-Moe say that “When a practitioner chooses to follow through with an unethical intension or behavior, they are not truly violating an abstract boundary, they are violating a human being” (2014, p. 41).

Taking into account the psychosocial role of touch, importance of attitude towards human body in physiotherapy practice, discussions on the definition of disability, and a widely adopted holistic model of a human being, it is difficult to comprehend why so little interest in specialist literature is devoted to psychological and philosophical analyses of human body and why it is still treated merely as a biomechanical object of manipulation (ten Have, 1998; Nicholls, Gibson, 2010; World Health Organization, 2011; Przyłuska-Fischer, 2013, pp. 138–141). Physiotherapist-patient relations should be the subject of ethical analysis, independently of the doctor-patient relationship.

### Axiological model of therapeutic relation in physiotherapy

The optimal model of physiotherapist-patient relations should include the values that are recognized as fundamental in various theoretical models of bioethics and rehabilitation, meet patients' needs and respect their rights. Also, it should take into account physiotherapists' views on values relevant to their profession, as well as recognize and prevent the emergence of emotional, psychological and moral problems connected with therapy. Particular attention in physiotherapeutic practice should be paid to the analysis of the role of body, touch, feeling of abashment and communication (Dadura, Wójcik, Gajewski, 2013; Długołęcka, Lew-Starowicz, 2015). The experience of somatic practitioners and the ethics of touch should also be given more importance in the ethics of physiotherapy. Benjamin and Sohnen-Moe rightly state that "The process of healing body, mind and soul can be a delicate, emotional journey that puts the client into places of great vulnerability. Respecting this process, or even the potential for this process, is a core reason why ethical intentions and conduct are vital for protecting clients" (2014, p. 11).

On the basis of the analysis of bioethical literature concerning the ethics of touch and physiotherapist's ethics and experience of professional physiotherapists who were members of the research team, it was assumed by us that the axiological model of therapeutic relation should take into account care, trust, sensitivity, honesty and moral integrity. According to Paul Ramsey (1977, p. 123) the relation between medical professional and patient is the case of a covenant agreement established by an absolute requirement of care for the patient. It is a relationship of ethical nature and



care constitutes the establishing value of bioethics. This view stems from the fact that medicine is in its essence a moral undertaking (and not realization of an agreement between the parties). Its main objective is to act for the sake of the patient. In his concept known as the ethics of care limited by fairness, Kazimierz Szewczyk (2009, pp. 70–72) gives a great importance to a fair division of care between current and future patients. On this basis, all the other aims of medical care will achieve the status of value provided they demonstrate care for the patient limited by fairness. The common assumption behind different theoretical attitudes to medical ethics of care is perception of care as a moral value, focus on the wellbeing of the subject of action, emphasis on the relational character of human relationships and critical standing towards abstract ethical principles (Dobrowolska, 2010, pp. 126–132).

Care as a medical ethics category can be characterized in various ways, for instance as an attitude expressing compassion, sensitivity, empathy and requiring from a medical professional loyalty towards the patient, appropriate knowledge and competence, understanding of patient's needs, communication skills and respect for patient's opinion. In case of physiotherapist-patient relation, one of the elements of effective communication is also the ability to interpret non-verbal signals, including those coming from the reaction of the patient to the type and strength of touch pressure applied by physiotherapist.

It is worth emphasizing that according to the American Physical Therapy Association (APTA, 2004) compassion is one of the main ethical values in physiotherapist practice. The authors of this document describe the concept of care as an attempt to understand individual experiences, emotions, needs and values of another human being, as well as the need for expressing empathy and respect. In European bioethics, the notion of care is covered by the Barcelona Declaration which stresses the value of "vulnerability". It states that "the vulnerable are those whose autonomy or dignity or integrity are capable of being threatened. As such, all beings who have dignity are protected by this principle" (Kemp, Rendtorff, 2008, p. 248). Also, the increase in the number of publications on disability written from the perspective of the moral ethics of care can be observed (Verkerk, 2001, p. 292; Kittay, 2011, p. 52).

Considering the different ways of defining the notion of care as a moral category in bioethics, it should be underlined that care is the main value of therapeutic relation in physiotherapy and should be understood as

a professional activity for the good of the patient with respect to their autonomy. Care ought to be regarded as the most important value comprising all the others on condition that the concepts of wellbeing and warrant of care should not be identified merely with an activity compatible with the opinion of a medical professional, but considerably broader i.e. taking into account other values crucial for the therapeutic relation such as autonomy, dignity, patient's hierarchy of values and their subjective opinion. It is particularly important since a therapeutic relation is usually unequal. Care might not be associated with total acceptance of paternalistic activities (like in the case of a parent caring for a child), tending to realize the good of the patient against their will.

In order to build trust in human relationships, it is necessary for both parties to have a positive attitude to other people, be sensitive to their needs, possess appropriate competences in a given area of activity and assume that the other party shows good will and benevolent intentions. Some authors question the role of the motive of action claiming that one can also trust a person who does not care about them. What seems important is a risk assessment rather than evaluation of the reason for action. Theoretical concepts of bioethics, however, ascribe particular importance to the issue of care as the right motive for action (O'Neill, 2002; McLeod, 2015). Trust is vital in a therapeutic relation, especially in life or health threatening situations, where patient has neither adequate knowledge nor possibility to control therapist's actions, thus loss might be even bigger in case of standards of conduct violation.

The concept of trust in a therapeutic relationship is conceptualized as multidimensional (Hall, Camacho, Dugan, Balkrishnan, 2002; Hupcey, Miller, 2006). A two-dimensional model of trust relies on two criteria: 1) compatibility of values and 2) compliance with standards and competence. Trust is based on the conviction that a medical professional will act in the best interests of the patient. The criterion of compatibility of values should be understood as a conviction that physiotherapist possesses and observes values which are the same as the values and interests of the patient. The criterion of professional competence, however, means that therapist is able to take proper action in order to improve the quality of life of a person requiring treatment.

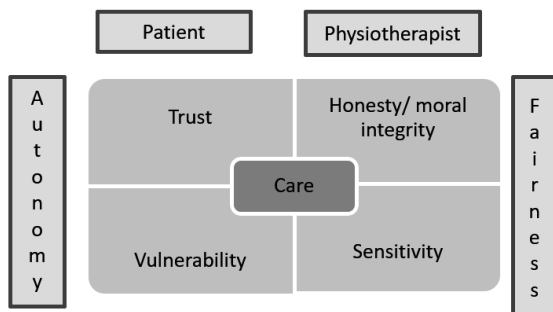
The notions of vulnerable patients and vulnerable social groups/populations are sometimes understood in bioethical literature in a strict sense of individuals or groups deprived (for various reasons such as intellectual

disability, age or legal issues) of the opportunity to make autonomous decisions and requiring particular protection and care. A wider interpretation of the concept applied in a philosophical context, however, refers to all people since vulnerability is regarded as a constitutive feature of a human being (illnesses, disability, death). A broader interpretation is used in bioethics to emphasize the role of sensitivity in a therapeutic relationship. Every patient is vulnerable which is connected with the experience of an illness or disability and the disproportion between knowledge and power on the one hand and the fear for own health and wellness on the other (Kemp, Rendtorff, 2008; ten Have, 2016, pp. 214–216). Due to the above presented specifications of work with patient's body, sensitivity to physical, mental and emotional reactions of patient, considering vulnerability is particularly important in physiotherapist's profession.

Sensitivity may be defined as the ability to consider all the factors which can have meaning in a therapeutic relationship and are connected with illness, suffering, the history of patient's life and disease as well as their psyche and hierarchy of values which, in turn, may have impact on the therapeutic relationship. Thus, it comprises: privacy protection, respect for patient's intimacy and privacy borders, keeping the distance, secrecy of information, appropriate verbal and non-verbal communication, ability to read feelings and signs given by patient, providing the sense of security and respect for patient's values.

Moral integrity or, in other words, honesty is fundamental for building the relations of trust and care. It is based on two elements: 1) integration of feelings, strivings, convictions, personal and professional values; 2) being faithful to own moral values in thinking and in practice or to basic norms expressing moral responsibilities and readiness to defend them in dangerous situations (Beauchamp, Childress, 1996, p. 490). Including this value in the model will enable to study what influence on the therapeutic relationship comes from the following factors: working conditions (consulting room, therapeutic room, surroundings, financial conditions, contract with National Health Fund, duration of the visit, form of payment, room equipment, availability of services), the patient (disease, disability, character, ability to cooperate and communicate) and physiotherapist's skills (courses completed, self-evaluation, education, communication skills, cooperation with the team).

The described model is presented in figure below.



### Values in a physiotherapeutic relation

Own elaboration.

The presented axiological model of physiotherapist-patient relation will be verified through qualitative studies with patients and quantitative ones with physiotherapists, conducted by an interdisciplinary research team consisting of a psychologist, sociologist, educator, bioethicist and physiotherapists.<sup>2</sup> The aim of the research will be identification of patients' expectations towards realization of the above-suggested model of values in physiotherapist-patient relationship and their confrontation with the values expressed and implemented in this relation by physiotherapists.

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### Abstract

The aim of the paper is to present morally significant features of the physiotherapist-patient relation (which distinguish it from other therapeutic relations in medicine), as well as to analyze the importance of body, intimacy and touch in the context of physiotherapist's work (particularly the moral meaning of touch and the risk of patient's physical, mental and emotional boundaries violation). The paper is also an outline of an initial axiological model of therapeutic relation in physiotherapy.