1 Introduction

Why does a physiotherapist need to know the law?

Typical situation

A 20-year-old girl, Sandra, was injured in a road accident when a lorry went out of control and crashed into her as she was walking along the pavement. She survived with severe brain damage and was transferred to a neurosurgical unit. The consultant neurologist warned the parents that she might never recover fully and in fact might stay in a persistent vegetative state. The nurses however encouraged the parents to be more optimistic and gave them contact addresses for voluntary organisations. Her father thought it might be best if she was taken off the ventilator, but her mother wanted all possible treatment and care to continue. Sandra remained in a coma for several months, during which time she had intensive physiotherapy. She developed a severe pressure sore as a result of a splint which had been badly applied at the time of the accident. She slowly recovered consciousness and had suffered a severe left sided hemiplegia. She moved to a specialist rehabilitation unit, returning home for the weekends. Her parents paid for her to have private physiotherapy at the weekends. The occupational therapist recommended that she should have a bed downstairs and should use a hoist for bathing. Sandra refused since she was determined to be independent. She was however concerned that her compensation following the road accident might be reduced the more she persevered in her exercises. She was also hoping to be able to drive a specially adapted car but, since she suffered epileptic fits following the brain injury, was advised to wait till these were clearly under control. Later she ended in-patient treatment, returning to the centre for check-ups and relying upon local physiotherapists for her care. They liaised with the centre.

Legal issues which arise

The facts describe a situation well known to many physiotherapists and repeated in various guises across the country every day. On examination however it gives rise to numerous legal issues. Some of them are shown in Figure 1.1 together with the chapters where that particular legal issue is discussed.

(1) Consent issues in treating an adult who is mentally incapable of making decisions. Do parents have the right to give and withhold consent? Chapter 7
(2) Standard of care in caring for a comatose patient. At what point and on the basis of what circumstances can active treatment be withdrawn? What rights do the relatives have? Chapters 10 and 25
(3) Giving information to relatives about prognosis and about voluntary groups. Chapter 7
(4) Liability for causing pressure sores and for treating them. Chapter 10
(5) Manual handling implications when a client refuses to use a hoist. Chapter 11
(6) Duty of carers when a patient with uncontrolled epilepsy wishes to drive a car. Chapter 16
(7) Duty of staff if patients are incapable of driving because of conditions such as epilepsy but refuse to accept their advice. Chapters 7, 10 and 16
(8) Entitlements to NHS and Social Services care. Chapters 20–24
(9) Financial support for disabled. Chapter 20
(10) Rights to have specially adapted wheelchairs and cars. Chapter 15
(11) Compensation following a road traffic accident. How it is calculated and the extent to which it will be reduced if a patient puts more effort into recovery? Chapter 10
(12) Who would have administered the finances if she had remained in a comatose state but had been awarded substantial compensation? Chapter 22

Figure 1.1 Legal issues arising from Sandra's situation

Physiotherapists and the law

Figure 1.1 shows only a few of the legal issues that can confront the physiotherapist in one particular case. It provides the justification for this book that aims to explain within the context of physiotherapy the law which applies to physiotherapists' practice. Physiotherapists need to have sufficient familiarity with the basic principles of law, so that when they are in a difficult situation they know immediately the laws that apply and the point at which they need to seek expert advice. Information from the Professional Advice Service within the Professional and Development Unit of the Chartered Society of Physiotherapy (CSP) shows that over 1000 queries are received each year on issues which have legal implications covering consent, employer/employee relations, the duty of care, confidentiality, social services, documentation, patients' rights, the NHS organisation and many other topics which show the need for physiotherapists to have some understanding of the law. All these issues are covered in this book.

Research was undertaken by Herman Triezenberg[1] to identify present and future ethical issues arising in physical therapy practice. Sixteen issues were raised: six involving patients' rights and welfare, five professional issues and five business and economic factors. Of these, 13 had never been discussed in previous physical therapy literature. The list is shown in Figure 1.2. It will be noted that each ethical issue also raises legal questions. The fact that the respondents to his questionnaires were US citizens is reflected in the number of topics relating to the financial relationship between therapist and patient and the dangers of exploitation and fraud. Legal issues arising from private practice are considered in Chapter 19. In a commentary on the research Ruth Purtilo,[2] Director of the Center for Health Policy and Ethics, Creighton University, Omaha states:

> The more physical therapists can do to create a broad base of understanding about the ethical issues facing the profession, the more likely we are to enter the new millennium prepared to make a meaningful contribution.

(1) Overutilisation of services
(2) Identification of the factors that constitute informed consent
(3) Confidentiality of patient
(4) Justification of fees charged
(5) Maintenance of truth in advertising
(6) Identification and prevention of sexual misconduct by therapists
(7) Maintenance of clinical competence
(8) Adherence to ethical guidelines in research
(9) Endorsement of equipment and products in which the therapist has a financial interest
(10) Determination of appropriate level of resourcing
(11) Involvement of therapists in business relationships that could have potential for patient exploitation
(12) Identification and elimination of fraud in billing
(13) Duty to provide treatment according to needs of patient irrespective of patient's personal or social characteristics
(14) Responsibility of therapists to respond to the environment
(15) Duty of physical therapists to report misconduct in colleagues
(16) Need for therapists to define the limits of personal relationships within the professional setting

Taken from Figure 5 of Triezenberg, H.L. (1996) The Identification of Ethical Issues in Physical Therapy Practice. *Physical Therapy* **76**, 10. With permission from Elsevier.

Figure 1.2 Ethical issues in physical therapy practice

Exactly the same point could be made about a legal understanding.

Definition of physiotherapy

A Royal Charter was granted in 1920 to the body which later became the Chartered Society of Physiotherapy and established as the only recognised examining and professional body for physiotherapists in the UK. It was authorised to:

> promote a curriculum and standard of qualification for persons engaged in the practice of massage, medical gymnastics, electrotherapeutics and kindred methods for treatment [and] to make and maintain lists of persons considered to be qualified to practise in such methods of treatment.

The new Curriculum Framework drafted by the CSP in 1996 and updated in 2002[3] defines physiotherapy as:

> A health care profession concerned with human function and movement and maximising potential. It uses physical approaches to promote, maintain and restore physical, psychological and social well-being, taking account of variations in health status. It is science-based, committed to extending, applying, evaluating and reviewing the evidence that underpins and informs its practice and delivery. The exercise of clinical judgment and informed interpretation is at its core.

Anne Parry points out the dangers of researchers defining physiotherapy in a minimalist way, i.e. by limiting it to exercise therapy, massage and physical applications, and then concluding that it is ineffective.[4] She urges 'Complain vociferously when "physiotherapy" is misused. If you don't care, no one else will.'

Once need for a physiotherapist has been determined, the physiotherapist will:

- agree long- and short-term goals with the patient, carer and team;

- determine the cost-effective type, frequency, duration, progression and mix of skills needed;
- give a degree of priority to the case;
- take the case on to the case load when a full care regime can be undertaken;
- continue to re-assess and review the treatment plan;
- discharge the patient when goals are met or progress is optimal;
- take full legal responsibility for his/her care.[5]

All these stages have legal implications which will be covered in this book.

The definition used in the CSP website is as follows:

> Physiotherapy is a heath care profession concerned with human function and movement and maximising potential. Physiotherapists work in a wide variety of health settings such as intensive care, mental illness, stroke recovery, occupational health and care of the elderly. Physiotherapy is certainly far more than fixing musculoskeletal sports injuries although that is perhaps the most common perception of the profession.

In the revised paper on the Scope of Professional Practice 2008, the definition of the scope of practice of physiotherapy is based on the four pillars (massage, exercise, electrotherapy and kindred forms of treatment) and is:

> any activity undertaken by an individual physiotherapist that may be situated within the four pillars (see above) of physiotherapy practice where the individual is educated, trained and competent to perform that activity. Such activities should be linked to existing or emerging occupational and/or practice frameworks acknowledged by the profession, and be supported by a body of evidence.

The Paper states that:

> Physiotherapy applies broad boundaries to its professional practice via the four pillars of practice contained within the Royal Charter. Whilst the first three pillars are narrowly related to specific treatment interventions, the fourth pillar (i.e. kindred forms of treatment) is suitably broad to allow physiotherapists to expand their expertise according to patient need.

In considering the scope of practice of the individual physiotherapist the Information Paper states that:

> Members may choose to work as either a generalist or a specialist practitioner, and may choose to practice within the first three pillars or practice, or they may wish to extend their practice into the fourth pillar of practice and develop further clinical skills aimed at enhancing patient care.

The CSP is the final arbiter about the nature of the practice of individual members and whether what they perform is identifiable as physiotherapy. Should there be a challenge to an individual's activity/competence, the CSP would be required to confirm that the individual was working within their personal scope of practice. Providing there is the evidence of an individual's competence to undertake the role/activity in question, and that the activity sits within the four pillars of practice, the individual would be covered by their PLI (Public Liability Insurance) as working within the scope of the profession.

This paper and the legal implications following from extending the scope of physiotherapy practice are considered in Chapter 4.

History of physiotherapy

Physiotherapy has ancient origins. In a review of the use of physiotherapy in health and lung conditions Diana Innocenti[6] discusses how massage and gymnastics were practised in the ancient world and were documented in China by Kong-Fu at around 3000 BC. There is also evidence of the use of massage and gymnastics for the improvement of health in Greece at around 700 BC. John Hutchinson presented his research on lung volumes and spirometry to the Royal Medical

and Chirurgical Society on 28 April 1846. Allen Mason's many articles on the history of individual aspects of physiotherapy practice provide an amusing insight into its ancient past and into the different forms of treatment.

The modern development of the profession that led to state registration of physiotherapy practice probably begins with the establishment of the Society of Masseurs in 1894. Jane Wicksteed has researched the history of the Chartered Society of Physiotherapy from 1894–1945[7] and describes how the original founders, nurses or midwives by training but all practising as masseuses, were anxious to establish their credibility as masseuses in the eyes of the public. They therefore set up a Council and Society, establishing examinations and membership rules and sought support from doctors as patrons and external examiners.

The development of the Society in the twentieth century illustrates the way in which new groups and new practices were assimilated within the main structure. In 1900 the Society became incorporated and linked in with Swedish physical exercises or gymnastics. New training schools were established and popularity increased. In 1916 Queen Mary became patron of the Society. In 1920 a Royal Charter was awarded and the Chartered Society of Massage and Medical Gymnastics (CSMMG) was formed with the amalgamation of the Incorporated Society of Trained Masseurs and the Institute of Massage and Remedial Gymnasts, the chairman being a member of the medical profession. Light and electrotherapy and hydrotherapy were added to the syllabus and examinations. In 1942 the name of the Chartered Society of Physiotherapy was adopted when the CSMMG and the Incorporation of Physiotherapists amalgamated. In 1986 the Chartered Society merged with the Society of Remedial Gymnastics and Recreational Therapy and 726 remedial gymnasts became members of the CSP.[8] In 1960 physiotherapists obtained state registration under the Professions Supplementary to Medicine Act 1960. In 2002 the Health Professions Council became the registration body for those professions which came under the Council for Professions Supplementary to Medicine and its role in registration, professional conduct and education is considered in Chapters 3, 4 and 5 respectively. In 1977 the autonomy of the profession was recognised in a Health Circular[9] and this has ultimately led to physiotherapists providing a direct access service to patients within specific specialties.

CSP strategy for 2005–10[10]

The CSP Vision and Mission for 2005–10 set three strategic priorities: building core services, putting members at the heart of the CSP and raising the profile and influence of the profession and the CSP with each strategic priority having the following strategic objectives:

- Building core services:
  - Strategic objective 1: robust foundations and infrastructure
  - Strategic objective 2: define and promote the membership package
  - Strategic objective 3: robust foundation for clinical practice and service delivery
  - Strategic objective 4: continue to improve the quality of our core services
  - Strategic objective 5: ensure diversity principles are integral to CSP service delivery
  - Strategic objective 6: understanding the issues facing the different countries
  - Strategic objective 7: partnerships with other organisations
- Putting members at the heart of the CSP:
  - Strategic objective 8: develop our representative structures
  - Strategic objective 9: support to members in influencing local health decision-making
  - Strategic objective 10: develop interactive CSP
- Raising the profile and influence of the profession and the CSP:
  - Strategic objective 11: raise the understanding of the general public

- Strategic objective 12: ensure that physiotherapy is 'at the table' when decisions are made.

The future

In May 2008 the CSP published a consultation paper on the future of physiotherapy.[11] The CSP wished to take advantage of the sixtieth anniversary of the NHS to make explicit its vision for the contribution of physiotherapy to the health and wellbeing of the UK population over the coming years and also its role in working with stakeholders to deliver this vision. The paper identifies the main changes and drivers affecting health and wellbeing services including designing and delivering services around service user need; improving access to services with 7-day cover and self-referral to a wider range of practitioners; more diverse settings for the delivery of health and social care including the voluntary and leisure sectors; greater integration of health, social care and education; new modes of planning and commissioning services; personal responsibility for health and wellbeing; self-care and self-management of long-term conditions; government drive to address health inequalities; skills no longer unique to one professional group; more effective use of support workers; greater focus on performance and quality management; practice to be founded on robust evidence, evaluation and continuing professional development; development of competencies; differences across the separate countries within the UK; technological advances and developments; demographic changes; changing systems of regulation and increasing significance of global issues in health and social care need and service delivery. The paper expands on the ways in which the physiotherapy workforce (defined as physiotherapists and support workers in diverse roles including clinicians, managers, educators and researchers) must develop to achieve this vision. It also sets out the role of the CSP in preparing new curriculum guidance in conjunction with education providers and employers and in setting out a new physiotherapy framework. A new Code of Practice and Conduct is to be prepared which will move away from a rules-based approach towards an ethical standards-oriented framework. The new Code will define professionalism, define evidence-based scope of practice, provide a resource to support members in their professional activity, define what people should be able to expect from physiotherapy and its workforce; provide bench marks against which members can self-assess their standards of practice, conduct and service delivery and reflect the full range of practice and settings. The emphasis in the new Code will be on individual responsibility for decision making and professional development; working with clients as equals and coping with uncertainty. The finalised paper is to be published in the summer of 2008 and will be followed by stage 2 and the development of new resources and tools overseen by an expert Steering Group.

The Darzi Review published its final recommendations in July 2008 in time for the sixtieth anniversary of the NHS. The reports are considered in Chapter 28.

Clinical interest and occupational groups of the CSP

The breadth of physiotherapy practice is supported by clinical interest groups and occupational groups within the CSP. They have been described by Ruth Dubbey[12] as serving

> as a forum for physiotherapists to encourage, promote and facilitate interchange of thoughts and ideas as well as providing expertise with education, practice and research in their specialty.

There are over 50 recognised clinical interest and occupational groups (CI/OGs) and many more non-recognised groups representing the diverse interests and specialties of physiotherapists. Criteria for a CI/OG to be recognised by the CSP were developed by the Professional Practice Committee in 1992 and were re-examined as part of the review of the CI/OGs during 2000. The criteria agreed by the Professional Practice

(a) That the groups have a minimum of 50 members of chartered physiotherapists committed to join a particular CI/OG that will have been in existence for a minimum of 2 years. Chartered physiotherapists must form at least 40% of the total membership of a multidisciplinary group
(b) That the proposed group represents physiotherapy within a distinct field of physiotherapy clinical practice or a specified occupational area
(c) That the proposed group can demonstrate its achievements since its inception in terms of the role outlined for groups (see point 2 in Appendix 3)
(d) That the objectives and 2-year action plan of the proposed group can be directly related to the role outlined for groups
(e) That the proposed group has an executive structure comprising at least the following roles:
Honorary Chair
Honorary Secretary
Honorary Treasurer
Diversity Officer
Research Officer
Public Relations Officer

If need be, more than one person can hold more than one role or one role can be shared between more than one person

(f) That the proposed group have a mechanism for regional networking, where practical
(g) That evidence is available to demonstrate links with other groups/networks as appropriate

Figure 1.3 Criteria for recognition of a Clinical Interest and Occupational Group (CI/OG)[13]

Committee in March 2001 are shown in Figure 1.3. The procedure for recognition is shown in Figure 1.4. There exists a Clinical Interest and Occupational Group Liaison Committee, which meets four times a year at the CSP headquarters. At the time of writing no new groups are being recognised as a review is being undertaken of processes and resources. This work is expected to be finished by December 2008 and may result in a change of the recognition criteria.

Recent developments in terms of training etc. and continuing professional development (CPD) are considered in Chapter 5.

The diversity and range of treatments provided by the physiotherapist means that the laws covered in this book will be extensive and many specialist areas will be discussed. First however it is necessary to understand the basic structure, language and sources of law and it is this to which we turn in the next chapter.

Conclusions

The publication of the CSP Strategy for 2005–10, the Scope of Professional Practice in 2008 and Charting the Future should enable the practice of physiotherapy to develop extensively but safely in several new directions. In particular, the recognition that the former fixed boundaries between different professions will disappear will present both opportunities and significant challenges with many legal implications. The role of the registered physiotherapist as a supplementary prescriber of medicines is considered in Chapter 15. Eventually physiotherapists may be recognised as independent prescribers. Such developments, once perhaps seen as an extremely unlikely part of physiotherapy practice, are a natural extension within the fourth pillar of 'kindred activities'.

(1) Groups seeking recognition will be invited to complete a pro-forma (Appendix 3) to submit evidence to the Professional Practice Committee (PPC)
(2) Recognition is granted for 5 years
(4) Re-recognition process
  (4.1) Every 5 years the form that was filled in for recognition will need to be completed again
  (4.2) The form will be sent out at least 6 months in advance, to make sure that the group has adequate time to meet and discuss what they have achieved in the past 5 years
  (4.3) Once the form has been returned to the administrative assistant, the form will be put forward to the Professional Practice Committee (via the CIGLC) for consideration
  (4.4) In the case of the form not being returned within 3 months of the re-recognition date (9 months after the form has been sent out), the group will no longer be recognised

Figure 1.4 Recognition process and re-recognition process for clinical interest and occupational groups

Questions and exercises

1 How would you define the core work of the physiotherapist?
2 To what extent do you consider it is appropriate to describe a physiotherapist as 'supplementary to medicine'? Consider this in relation to the extended scope practitioner that is considered in Chapter 4.
3 Do you consider the personal beliefs and philosophies of the physiotherapist are relevant to her work? To what extent, if any, should they be taken into account by a prospective employer or client?
4 What are the legal implications for the physiotherapist of the CSP paper Charting the Future of Physiotherapy and of the Darzi Review of the NHS (see Chapter 28)?

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