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Development of a Statement on Autonomous Practice: Practice Committee, Section on Geriatrics

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Special Interest Paper: Development of a Statement on Autonomous Practice

Practice Committee, Section on Geriatrics

Introduction

Vision 2020[1] is the official vision statement of the American Physical Therapy Association (APTA). Drafted by the APTA House of Delegates in 2000, this statement contains 6 elements: autonomous physical therapist practice, direct access, Doctor of Physical Therapy and lifelong education, evidence-based practice, practitioner of choice, and professionalism. Autonomous practice has been operationally defined by the APTA primarily through its characteristics: "Physical therapists accept the responsibility to practice autonomously and collaboratively in all practice environments to provide best practice to the patient/client. Autonomous physical therapist practice is characterized by independent, self-determined, professional judgment and action." The Section on Geriatrics has undertaken the endeavor to further elucidate this definition to educate and empower physical therapists to practice autonomously for the benefit of their patients/clients and society.

The purpose of this paper is to support the Section on Geriatrics Strategic Plan 2010-12, particularly in addressing Major Goal 1: Promote and support autonomous physical therapist practice with the aging population, Objective 1.1: Promote and facilitate autonomous practice across various settings and employment arrangements, Strategy b: Adopt a section statement on autonomous practice in geriatric physical therapy.

In 2010, the Practice Committee (the Committee) began the charge of the Section on Geriatrics to produce a statement on autonomous practice. The Committee chose an iterative process based on that used by the Neurology Section beginning in 2007 that included a forum[2] and culminated in a statement[3] and perspective piece[4] on autonomous practice in neurologic

physical therapy. The process began with discussions of autonomy based on independent readings on autonomy and committee members' personal experience across various practice settings and employment arrangements. A compilation of this preliminary work was presented at the APTA Combined Sections Meeting 2011.[5] The intent of this project was to use a consensus-based process to include not only the perspectives within the Committee, but also input from interested members; accordingly, comments and feedback were then solicited on the Web site of the Section on Geriatrics and by email to Section members using an online discussion board over a 3-month period. Twenty-four comments were received. Responses tended to fall into 2 broad categories: substantive (in which members reflected on their own developing understanding of autonomous practice, responded directly to an aspect of the Committee's preliminary work, or both) and supportive (in which members expressed views that were generally consistent with the Committee's preliminary work). The Committee reviewed these comments, continued the group process, and then produced the final statement (Table 1).

Explanation of Statement

Item 1

First, autonomous practice means practice in collaboration with the patient/client and other providers as equals, not practice in isolation from other providers. This interpretation is supported by the Vision 2020[1] definition of autonomous practice, which specifically identifies autonomous practice as a collaborative process, as well as the Vision 2020 definition of professionalism, which explicitly cites the need to work together with other professionals. Thus, autonomous practice is collaborative practice among members of the patient/client-centered health care team. In this model, the physical therapist functions not as a technician, subordinate to and relying on the direction of another provider, but rather as a professional, practicing to the

fullest potential of his or her education and scope of practice. For example, a physical therapist would not carry out an intervention that he or she knew to be contraindicated by the patient's/client's condition; instead, he or she would discuss the contraindication with the patient/client and the referring provider (if practicing by referral) to determine the most appropriate course of action. The physical therapist would then accept full accountability for the success or failure of the determined course of action.

Item 2

Second, autonomous practice is distinct from, and possible in the absence of, direct access. Direct access is defined in this way: "Every consumer has the legal right to directly access a physical therapist throughout his/her lifespan for the diagnosis of, interventions for, and prevention of, impairments, functional limitations, and disabilities related to movement, function and health."[1] Whether a person is able to access a physical therapist directly or whether he or she accesses services through referral, when the physical therapist acts in concert with the patient/client to exercise clinical judgment, then a first step toward autonomy has taken place. When the physical therapist takes action toward the chosen judgment in a professional manner, including collaboration with the patient/client and all those involved in the patient's/client's care, then a second step has been taken toward autonomy in practice. If the physical therapist understands that a referral is a request for consultation rather than an order for what is to be performed, then autonomy is possible. A physical therapist acting in a purely technical role does not exercise independent clinical judgment or action and does not accept accountability for the actions chosen, instead deferring responsibility back to the referring provider or the patient/client for failed interventions. A physical therapist acting autonomously exercises independent clinical judgment and action (through referral or not) and accepts accountability for actions chosen.

Direct access and autonomous practice are both a benefit to the patient/client, but direct access is merely a mechanism by which services are accessed, while autonomous practice is the level at which the practitioner chooses, and is able, to provide services.

Item 3

Third, autonomous practice is a characteristic of entry-level clinical practice as well as advanced clinical practice. Autonomous practice should begin in the physical therapist education program and progress through the individual physical therapist's ongoing professional development, including formal education (eg, residencies, fellowships, additional degrees), mentorship, and clinical experience. The document "Professional Behaviors for the 21st Century,"[6] based on the earlier work, the "Generic Abilities," of the faculty of the physical therapist education program at the University of Wisconsin-Madison, incorporates the concept of a progression in professional behaviors from beginning-level, intermediate-level, and entry-level to post-entry-level practice. As with professional behaviors, autonomous behaviors require clarification and role modeling by faculty and clinical instructors. Students need to be empowered in their learning such that decision making, action on decisions, and accountability become a natural phenomenon. The fostering of interdisciplinary education also helps form a basis for the collaborative spirit of autonomy while building trust and understanding with other health care professionals. Students need to be given the opportunity to test their abilities to practice autonomously and be accountable to that standard through self-reflection and feedback from faculty and clinical instructors.

Item 4

Fourth, autonomous practice is possible for physical therapist practice in all settings and areas of practice in today's health care environment. This assertion is supported by the Vision

2020[1] definition of autonomous practice, which includes the language "in all practice environments." Practicing autonomously consists of 2 steps. First, the practitioner must demonstrate a willingness to reject dependence and accept accountability for decisions and actions. As such, autonomy begins at the level of the individual practitioner, with this willingness as an internal factor. Second, the practitioner must translate this willingness into decisions and actions in collaboration with the patient/client within the context of the health care environment, which is subject to external factors. While autonomous practice does not differ across practice settings or areas of clinical practice, external factors can influence the degree to which autonomy is possible in any given situation. For example, there may be greater access to physicians and other providers in the hospital setting, providing greater opportunities for communication and thereby facilitating the collaborative process. In a private practice, there may be less capability for instant access to other providers for collaboration, making this aspect of autonomous practice less likely, but the physical therapist in a private practice may have greater control over needed resources and economic decision making than those in acute care.

Thus, autonomy is not a static all-or-none dichotomy, but rather is a matter of degree based on the environment and opportunities that exist at a particular time. External factors that impact the practice environment range from the micro level (eg, the autonomy of others, including patients/clients, other health care providers, and administrators; characteristics of specific provider agencies) to the macro level (eg, decisions made by other health professions, insurance companies, and government agencies; regulatory issues; and reimbursement models). For example, consider these 2 indicators of "Integrity" from "Professionalism in Physical Therapy: Core Values"[7]: "11. Choosing employment situations that are congruent with practice values and professional ethical standards" and "12. Acting on the basis of professional values

even when the results of the behavior may place oneself at risk." Health care coverage, benefits, and other resources impact decision making and care; however, while these external forces can serve as facilitating or constraining factors, they do not stand in the way of the practitioner's choice to practice autonomously, nor do they exempt the practitioner from accepting accountability and engaging in advocacy when needed. Autonomous practice can exist despite external factors in the health care realm, but these external factors can influence how easy or difficult autonomous practice is for the physical therapist, the availability of needed resources, and ultimately the range of outcomes that are possible. In this sense, autonomy means providing the care that individuals deserve to the best of one's ability and striving to do so even in the face of constraints within the health care realm.

Item 5

Finally, autonomous practice has key aspects that are correlated with the core values of professionalism in physical therapy. In the preliminary stages of the Committee's work, multiple sources pertaining to autonomous practice[1,8-11] were reviewed and discussed, with each Committee member bringing his or her personal knowledge and experience regarding autonomous practice to the discussion. Documents related to professionalism in physical therapy[1,6,7] were also reviewed by the Committee because of a recognition that much of the discussion surrounded concepts related to professionalism as well. Professionalism is defined in multiple sources, including Vision 2020[1] and "Professionalism in Physical Therapy: Core Values,"[7] by the APTA, as well as in "Professional Behaviors for the 21st Century."[6] "Professionalism in Physical Therapy: Core Values" identifies 7 core values that comprise professionalism: accountability, altruism, compassion/caring, excellence, integrity, professional

duty, and social responsibility. Each of these values, in turn, is defined, and sample indicators are given.

Through discussion and consensus, the Committee identified a number of similar aspects of autonomous practice embedded within the existing core values. Table 2 outlines the 12 aspects identified, including (1) accountability; (2) advocacy; (3) caring; (4) collaboration; (5) communication; (6) ethics; (7) evidence-based practice; (8) excellence; (9) lifelong learning/continued competence; (10) provision of excellent, patient-centered care that addresses the whole person; (11) screening for referral/clinical decision making/ differential diagnosis; and (12) serving as a role model. The Committee acknowledges that autonomous practice and professionalism are distinct concepts; however, the recognition that, in demonstrating the behaviors of professionalism in physical therapy, each practitioner is simultaneously fostering the ability to practice autonomously is important.

Clinical Relevance

As the profession of physical therapy continues to move toward the fulfillment of Vision 2020,[1] physical therapists must understand the elements and apply them to their clinical practice. One of the elements of APTA Vision 2020 is autonomous practice. In today's health care environment, autonomy exists through collaboration with the individuals we serve and other health care professionals and has a foundation in the core values of professionalism in physical therapy. In a sense, autonomous practice is professionalism in action. Autonomous practice is possible in every practice setting regardless of practitioner experience level, employment status, or direct access capacity.

This statement on autonomous practice is intended to educate and empower physical therapists to practice autonomously for the benefit of their patients/clients and society. Far from

being an esoteric ideal, autonomous practice is a model of routine clinical practice that is not only pragmatic, but also essential for the provision of optimal patient/client care. Some physical therapists may be surprised to discover that, in fact, they are already practicing autonomously. We hope that this recognition inspires them to serve as role models for their peers as the profession of physical therapy continues to reach the full realization of Vision 2020.[1]

Acknowledgements

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