

THE CHANGING PROFESSION

AN INTERNATIONAL PERSPECTIVE

INTRODUCTION

Coincidentally with the invitation to deliver this prestigious address in honour of Molly Levy, I came across an article by Michael Wright in the London Daily Telegraph under the title, "Unaccustomed as we are, the lecture stages a come back" which caused me some immediate concern as to whether it would be wise to accept the invitation. The writer pointed out that there was a time when public lectures were an opportunity for grand British explorers to share their new-found knowledge with expectant Victorians, or for Oscar Wilde to wow America with his new-minted Aestheticism, but more recently, TV and radio had made the "live" talking head almost redundant:

"Even for university students, lectures are often a tedious anachronism, strictly for sad people: the endless attended by the friendless".

I was not encouraged by these observations, but more was to come! The writer was quick to point out that despite a number of attempts to abolish the university lecture it persists largely because if it is done away with the students don't do anything and there is still the demand for the shamanic figure in front of them.

"It seems to be a deep human need to be bored by someone who is actually present".

Hardly reassuring!

But, as you see, I did accept. Two reasons overcame my reservations; firstly, I knew that, despite Michael Wright's observations, I would be in the company of friends and, most importantly, the occasion would provide the opportunity to pay my tribute to Molly Levy – a lady for whom we all share the most profound respect for her warmth, humanity, loving spirit and dedication to our profession.

I first met Molly when I came to South Africa in connection with the selection of visually impaired students for my programme in London. Molly served on the South African National Council for the Blind Physiotherapy Selection Panel in which capacity she was respected for her integrity, understanding and the goodness reflected in her gracious counsel. I greatly appreciated the warmth of her personality. The essence of Molly Levy

is encapsulated in a description of her that I received from another friend and colleague, as the "The Mother of South African Physiotherapy".

THE CHANGING PROFESSION – AN INTERNATIONAL PERSPECTIVE

In years to come there will be no doubt in the mind of anyone reviewing your Congress as to the primary interests of South African physiotherapists in 1997.

The titles and content of the lectures, workshops and other elements of the programme emphasise new approaches, techniques and the changes which are currently taking place in the profession as it is practiced in South Africa. It is a time of great change for us all and the changes which are taking place here are reflected throughout the world. At this time of so much change I would be surprised if there were not mixed emotions and some reaction to it; for just as change can bring a new vitality to practice it can also be threatening for those who prefer the status quo.

The following quotations are apposite:

"Change is not made without inconvenience, even from worse to better."

Dr Johnson's preface to the English Dictionary.

"A State without the means of some change is without the means of its conservation."

Edmund Burke (1729-1797)
Reflections on the Revolution in France. Perhaps some would find an echo of their true feelings in the immortal words of the second verse of Henry Francis Lyte's hymn, 'Abide With Me':

*"Change and decay in all around I see;
O Thou who changest not, abide with me."*

A recent article in the *Journal of the Royal Society of Medicine* under the title, 'Responding to Change – or Despondent and Estranged' (Coni – 1997), the writer draws attention to the sagging morale of consultant physicians in the UK as reported by the Royal College of Physicians. It pinpoints the reason as too much change happening too fast. Consultant physicians are not alone in this view.

DAVID PG TEAGER PRESIDENT WCPT

Every profession has to face the inconvenience of change to preserve its relevance in and for the society it seeks to serve. Furthermore, we all need to consider the international dimensions of our contemporary professional practice in the context of the changes taking place in the "global village" in which we all operate. What is the "global village"? What are the forces that now impact on the national and international dimensions of our health practice? These are issues that demand our fullest consideration.

THE HISTORICAL PERSPECTIVE

The unstable nature of our contemporary practice can perhaps be best appreciated in the context of an historical perspective and an assessment of our future prospects.

Physiotherapy had one of its most important origins in physical education; the knowledge and functions of the human body and the effect of exercise on its systems in health and disease. A comprehensive study and knowledge of anatomy and physiology, particularly that of the musculo-skeletal system, being essential to our practice. The profession owes much to a long line of educators who recognised and saw the teaching of anatomy and the study of human movement as the fundamental bases of our clinical practice.

Here, I would like to pay personal tribute to my friend Ione Sellars who, as a staff member of UCT, gained the utmost respect of colleagues and students as an anatomist of the highest order who conveyed the love and relevance of her subject to all those who came under her influence both as undergraduates and post graduates.

I see no reason to shift this emphasis in physiotherapy education programmes. In fact, there is every reason to reinforce the central position of living anatomy and kinesiology in the education of the physiotherapists of the future. I also have no doubt that teachers of physiotherapy are best placed to emphasise anatomy and movement studies in a relevant and meaningful way within the practice of

physiotherapy.

The other roots in our healing tradition of which we should be unashamed are massage and the use of physical agents including hydrotherapy. Research devoted to the appropriate use and efficacy of these modalities is now justifying physiotherapy as an essential element in all health care programmes. The knowledge and handling skills we possess are recognised as vital in the rehabilitation of physically handicapped people. Wars, epidemics and accidents occasioned by industry and the motor car together with the surviving generations of physically handicapped children made, and continue to make, physiotherapists evident as full and essential members of the health care team. In recent years increased social equality and the efforts being made to integrate disabled people and the chronically ill into the community have contributed to a growing awareness that physiotherapists fulfil a vital role as key workers in the rehabilitation process and that their practice outcomes are morally justified and socially significant. The Standard Rules for the Equalisation of Opportunities for Persons with Disabilities adopted by the United Nations General Assembly at its 48th session on 20 December 1993 (Resolution 48/96) were unanimously endorsed by the World Confederation for Physical Therapy at the 13th General Meeting in Washington.

Physiotherapists have always seen their contribution to health care as greater than the sum of its parts. They will continue to have a significant influence in regenerating the maximal quality of life for their patients which is the ultimate goal of all rehabilitation processes.

My picture of the development of the practice of our profession would be incomplete without reference to the increasing role of physiotherapists in preventive medicine, health promotion, health education and counselling. Physiotherapists have a unique knowledge of normal and impaired movement patterns and their relationship to injury. This is beautifully articulated in a recent study under the title, 'Physiotherapy practice: Practitioners perspectives' (Sarah Beeston and Helen Simonds – Physiotherapy Theory and Practice). The physiotherapists involved in the study viewed their practice as, "Working for change in relation to complex practical problems and working in harmony with

others in order to maximise a patient's functional ability".

In their view, the unique contribution of the physiotherapist within the multi-disciplinary team was to manage the musculo-skeletal system of the patient.

"There was no gold standard to be attained. The goal was change in patient status."

In summary it is my belief that the professional goals we pursue find justification in what is good for humankind and what all people have a right to demand of life. Physiotherapists work in an open and equal partnership with their patients, their relatives and carers and other health professionals to achieve these goals.

THE CONTEMPORARY REALITY

"We live in a moment of history where change is so speeded up that we begin to see the present only when it is disappearing"

RD Laing – *The Politics of Experience.*

It is important to sense the urgency with which we need to address contemporary professional problems so that we are not overtaken by events. I am not alone in highlighting the importance of this consideration which finds an echo in the lectures of Ruth Grant and other speakers at your Congress. But, this is not a new theme for physiotherapists: Heidi Paatero in her keynote address to the WCPT Stockholm Congress made the following statement:

"A profession should not be regarded as an institution which protects acquired modes of functioning in its own niche. It should not be regarded as a body of knowledge and skills the possessors of which are conservative and fearful of change. Instead it should be regarded as developing and changing functions – as something both open and dynamic. It defines its own goals – anticipates change, participates in the development of society and readily re-examines its boundaries and the content of its activities".

Heidi Paatero – *Physiotherapy in future Prospect.*

WHERE ARE WE AND WHERE ARE WE GOING?

Physiotherapy is a practice-based profession and differences in practice and levels of practice are inevitable. These differences can be identified both within and outside national boundaries. In fact, the strength of contemporary professional practice lies in the ability of individual physiotherapists to respond to the varying needs of each patient in the most

effective and appropriate way and to adapt their practice to take account of the society in which they and their patients function. If physiotherapy is to fulfil its early promise as a dynamic profession every physiotherapist must have an open mind and the readiness to change their practice. However the tensions inherent in the flexibility of autonomous practice, which mould the character of the contemporary profession, have also the potential to pull it apart.

It is therefore imperative to identify, validate and seek to preserve the key elements of our practice which distinguish it from other professions. Everyone has a view as to what physiotherapy is from the perspective of their own practice but in such a dynamic, evolving profession it is extraordinarily difficult to focus the national and international common denominators of corporate practice. Studies which introduce objective criteria into the analysis of what physiotherapists are actually doing with their patients make a vital contribution to the national and international debates that are taking place to determine the essential elements of contemporary physiotherapy practice. However, we must resist the temptation to make a definition of physiotherapy that fossilises our professional activity within its current scope of practice.

QUALITY

The first objective of WCPT is to encourage high standards of physiotherapy education and practice and I am delighted that the 13th General Meeting of the Confederation in Washington established a working group on Quality. Their draft report was endorsed by our recent Executive Committee Meeting in Istanbul.

The report outlines a vision and principles for quality in physiotherapy, describes WCPT's role in quality in physiotherapy and outlines a project to achieve the vision. Important activities within the project are conducting an inventory of quality initiatives within our Member Organisations, the identification of potential leaders in the field and the development of an assessment tool.

In developing standards WCPT will recommend the consideration of a number of elements including:

- Prevailing values, conditions and goals to advance the profession.
- Valid principles with their measures.
- Strategies to meet the changing needs of the profession.

- Networking the agreed standards to members of the profession, employers other health professionals, governments and the public.

Perhaps it is timely to remind ourselves that we must constantly watch the “quality” of our practice for its equity, efficiency, effectiveness, appropriateness, acceptability and accessibility. In any reflection of our contemporary professional situation we must resist the temptation to be insular and take account of the trans-national nature of the societies in which we now operate. The impact on our professional practice is likely to be considerable.

THE GLOBAL VILLAGE

Recently I came across Donella Meadows concept of the “global village” in which she gives a snapshot of a community of a thousand people based on the rigours of a statistical analysis of the macro-economic and geo-economic forces that affect us all. It’s a riveting study!

So, if the world were a village of a thousand people what would it be like?

Such a village would include 584 Asians, 124 Africans, 95 Europeans, 84 Latin Americans, 55 inhabitants of what used to be the Soviet Union, 52 North Americans, 6 Australians and New Zealanders.

The village would have considerable difficulty in communicating. 165 people would speak Mandarin, 86 English, 83 Hindi/Urdu, 64 Spanish, 58 Russian and 37 Arabic...

The other half of the village would speak 200 other languages in a descending order of frequency from Bengali, Portuguese, Indonesian, Japanese, German and French, etc.

One third of the village would be children and only half of those children would be immunised against preventable infectious diseases such as polio.

Two thirds of the total population would not have access to clean, safe drinking water.

The village would have a total budget each year, public and private, of over \$3 million – the top 200 people would receive 75% of the income of the village and the bottom 200 people would receive only 2% of the income. Of the total budget of \$3 million, \$181,000 would be spent on weapons and warfare, \$159,000 on education and \$132,000 on health care.

In the next year, 28 babies would be born only 3 of whom would be born to the richest 200. Ten people would die; three from starvation and one from cancer. One would be infected with the HIV virus but would probably not develop Aids until a later date.

Of the 650 adults in the village, 50% would be illiterate... most of these women living in the poorer part of the village.

The village would have enough explosive power to blow itself to smithereens many times over. These weapons would be under the control of 10% of the population.

83% of the fertiliser would be allocated to the 40% of the croplands owned by the richest and best fed 270 people. The grain yield of this land would account for 72% of the total harvest of the village. The remaining 60% of croplands would be allocated the remaining 17% of the fertiliser as a result of which the average grain yield on that land would be 28% of the total harvest gathered to feed 73% of the population.

Donella Meadows in “If the World Were a Village” Independent on Sunday 20.10.96.

BRIDGING THE GAPS

WHO Report 1995

“The worlds biggest killer and the greatest cause of ill health and suffering across the globe is listed almost at the end of the International Classification of Diseases. It is given the code Z59.5 – extreme poverty” So opens the 1995 WHO Report... “Bridging the Gaps”.

It continues, “For most people in the world every step of life, from infancy to old age, is taken under the twin shadows of poverty and inequity and under the double burden of suffering and disease”.

Largely as a result of this report there is a worldwide professional activity to reduce the harmful effects of poverty.

Why?

Firstly, anybody interested in health has to pay attention to wealth. It is the single most important driver of health worldwide.

Secondly, a great deal of research is under way into inequalities in health. It affects every part of medicine and it is becoming clear that even in developed countries, relative poverty (having an income substantially below the mean for that society) has as great, if not greater influence on health as absolute poverty

(lacking the basic means to live). This research is leading to important discoveries on how social pressures lead to disease outcomes.

Thirdly, things are getting worse not better. The gap between the rich and the poor is tending to widen both between and within countries with inevitable effects on health.

Lastly, there is increasing evidence as to what health workers and health services can do to diminish the harmful effects of inequalities in health.

At the same time as the net worth of the worlds 358 richest individuals has risen to equal the combined income of the poorest 45% of the worlds population, the overall gains in health are being overshadowed by a number of factors. These are a decrease in life expectancy in eastern and central Europe, a rise in infant mortality in some areas, dramatic increases in diphtheria, typhoid and whooping cough and one third of the world’s children under 5 show evidence of malnutrition as judged by their weight for age.

WCPT is a member of Action in International Medicine. A conference in London, jointly sponsored by AIM and WHO, which I recently attended prompted the following statement:

“THE LONDON DECLARATION”

All institutions and associations of Health Professionals should:

- Urge political leaders of their countries to make public commitments to reduce poverty and improve the health of their populations.

- Exchange and disseminate information on trends in health and poverty and on successful and failed interventions directed at tackling their causes and effects.

- Recognise, harness and enhance the potential energy resource of poor people themselves.

- Work to direct more health resources to the district level of their healthcare systems.

- Foster and coordinate intersectoral and interagency collaboration, especially at district level.

- Work to eliminate the marginalisation of population groups such as lonely elderly people, disabled people and refugees.

- Ensure that front line health workers have appropriate training and the ability to access and use relevant information.

- Influence public opinion by liaising with national and international media.
- Lobby governments to reduce their economic dependence on harmful activities, such as the arms trade, narcotics, nicotine and alcohol.

I believe that we can all play a part in this important initiative by making a personal response to its challenge. These are prime issues that must be addressed both at a corporate and personal level. Many argue that our services should:

- be directed to those with most health needs which would automatically include people living in poverty,
- be more accessible, appropriate and user-friendly for those least well off in society and
- incorporate "measures of poverty" into our practice profiles to establish the connection between poverty and health status.

Perhaps the least we can do is to reflect on the need for equity in our own practice.

A FRAMEWORK FOR THE FUTURE

In this analysis I would like to draw your attention to the work of John Naisbitt, an American social forecaster who makes predictions for the future based on a dynamic analysis of what the world is today. It is such a sensible analysis that it has an irresistible appeal. Furthermore, his analysis has already been seen as uncannily accurate in many respects, particularly the more general trends which are well documented and can be recognised within our present day living experience. They will have an equally profound effect on our professional development and the bureaucracies within which most of us function. Some of the changes are summarised as follows:

- The move from an industrial society to an economy based on the creation and distribution of information; the computer age.
- A society moving in dual directions toward "high tech" but with the will to moderate its influence on our lives by the compensating emphasis on the value of "high touch".
- Global interaction in which individual states cannot operate in economic isolation.
- The restructuring of a society run on short term considerations to one run on the basis of a much longer time frame; forward planning.

• The pressure in cities, states and organisations to act from the bottom up; grass roots power and networking.

• The shift from institutional dependence to more self-reliance.

• The challenge to the relevance of representative democracy in the era of instantaneously shared information; consensus politics based on referenda.

• The move from hierarchical structures which are failing in favour of informal networks in which rewards come by empowering others, not by climbing over them.

• The move of people from the industrial heartlands; we are where we live.

• The establishment of a new society - from one with a limited range of personal choices to a freewheeling multiple option society.

John Naisbitt *"Megatrends - Ten New Directions Transforming Our Lives"* Macdonald & Co London and Sydney.

Each trend deserves some exploration for its effect on the future development of our profession. Many are interrelated and impinge on each other. Unfortunately time prevents a comprehensive analysis. However, there are two trends of particular relevance for physiotherapists that I would like to draw to your attention:

1. The shift from institutional dependence to more self-reliance.

The present tendency to meet every health challenge with more powerful, costly drugs and highly expensive technological interventions will have to be balanced by the promotion of self help systems in which prevention is seen as a cheaper, preferable option to cure. In short, the emphasis has to shift from national sickness to national health initiatives directed to achieve an improved quality of life for all peoples. If the transition is to be completed successfully it will be necessary to recognise that health education and promotion, while longer term objectives, are more effective options than reactive clinical practice. It is my belief that physiotherapists will welcome the evolution of this new emphasis in health care provision particularly if it allows them to direct their skills to where they know they can be most effectively and efficiently used. We already play an important part in health care education and fitness programmes from coronary care to sports fitness; we are already involved in the physical, intellectual and spiritual empowerment

of our patients; we are in an ideal situation to assist our patients, their relatives and their carers to move away from institutional buffers to self-help systems in which they can take increased responsibility for their own health needs... we have been doing it for years!

In the changing pattern of health care, physiotherapists have a credible and important role to play... confirming a fundamental principle of our current practice that physiotherapists do things with rather than for their patients.

But are we reaching all the patients who could benefit from our service ?

2. A society moving in dual directions toward "high tech" but with the will to moderate its influence on our lives by the compensating emphasis on the value of "high touch".

It will be obvious to you that nowhere is the high tech revolution more evident than in our health care systems. The advantages are many and obvious but unfortunately the more technology that enters our systems the less personal they become and for many patients our hospitals are no longer desirable places in which to be born, treated or to die. It is also evident that despite the technological advantages, society believes that the medical institutions are failing them at a personal level. As a result people are moving away from the medical model of health care to alternative practitioners where they perceive their needs are more appropriately met. People want time and technology and it is no surprise to physiotherapists that patients value the time element of care as much, if not more, than the technology.

Taking an international perspective it has been observed that in the past two decades the affluent world responded to the health care needs of the developing world with aids programmes that, in general, featured high technology and high cost. This pattern of aid resulted in the recipients concentrating their health services in major cities and universities thus having no real impact on the health care needs of the majority of their peoples residing in the rural areas. This was powerfully illustrated in an article written by Professor Smilkstein of the University of Washington and other authors who had worked as physiotherapists in developing countries. ('The Role of Physical Therapists in Primary Care in the Developing World'. Smilkstein *et al* Clinical Management, Vol.4, No.1

American Physical Therapy Association).

The authors use a pyramidal model to illustrate the weakness and disadvantages of this pattern of health care provision. (Figure 1)

It was the injustice of this pattern of provision which led to initiatives to shift the emphasis of aid to the primary care sector. The initiative became known as the 'Health for All by the Year 2000' campaign.

In the current world recession the race to 'high tech' health care has impoverished all our health care systems. Increasingly health services are seen to be in turmoil as a result of infinite demands being placed on systems with increasingly limited resources available to fund them. There is an international imperative to shift the balance from high tech tertiary provision to high touch primary care.

RESTRUCTURING HORIZONTALLY

Within any restructuring process it is important to remember that physiotherapy is the profession of high touch and it is appropriate for us to exert our leverage to shift the axis of health care in ways that we know will improve the quality of life for those in our care. We can do this in the context of the World Health Organisation's recognition of rehabilitation as an essential component of primary care. Priority should be given to the social, economic and medical needs of all handicapped people in our communities. Strategies to meet these needs must be developed.

The question is how our systems can be restructured horizontally, what effect this will have on our professional practice and whether we have the will to effect the necessary change?

There is only time to itemise some of the contemporary issues that need to be addressed:

- Political and professional initiatives have to be taken to facilitate adequate health care provision at community level.
- Physiotherapists need to be increasingly involved in primary health care issues and practice involving health promotion, disease prevention, delivery of care and the direction of rehabilitation programmes.
- Increasingly physiotherapists will function as part of a multidisciplinary health care team each member of which will contribute to the practice objectives.
- Physiotherapists must develop appro-

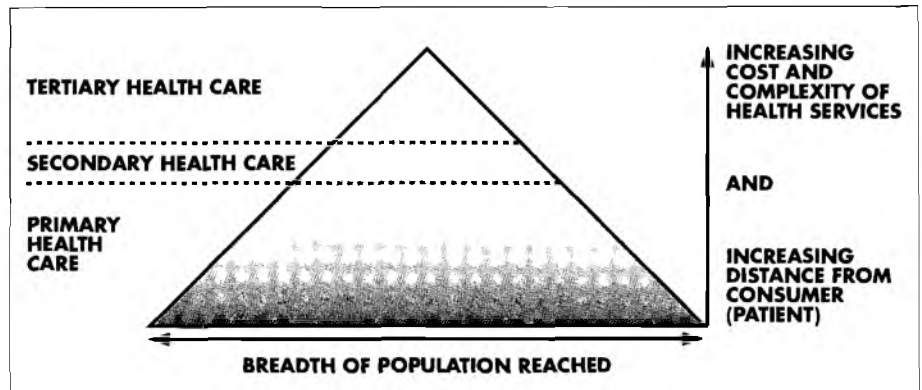


Figure 1

priate policies and training for the employment of support personnel to be able to provide effective and efficient services demanded throughout a wide range of community based programmes.

- Employment structures and practices will need to be redefined to allow those working at a tertiary level to contribute within community based programmes by teaching, research and service projects. Those working at community level should be facilitated to participate in tertiary education and practice programmes.

Such horizontal structuring has the potential to improve the quality of life for many handicapped people who might otherwise remain untouched by the development of high tech medical resources. There is no doubt in my mind that such horizontal structuring is preferable to other options including the rationing of services within the available funding.

THE MANAGEMENT OF CHANGE

No one can ignore the macroeconomic and geoeconomic forces that are affecting us all. No one can ignore the existence of the computer and information technology. The inability of governments and politicians to find solutions does not isolate us from the need to seek solutions from where we are as individuals and corporately as members of an important health care profession.

In the past more stable era of our profession everyone "knew their place" and as a profession we had little room to manoeuvre or the opportunity to apply political leverage. In these less stable times we can exert far more professional and political influence. It is a time filled with opportunity to shift the axis of health care in ways that we know can improve the quality of life for many more people.

Change may mean learning new skills, creating new relationships and adopting new routines. It means abandoning the predictable and known ways of doing things in favour of new approaches and techniques. At best it will be unsettling – at worst a disruptive experience, but change will not occur if we are so intoxicated with our present success that we fail to catch a vision of the place we wish to head for.

"The engine for change is dissatisfaction, the brake is fear".

(‘Managing to Survive’ Sir John Harvey Jones.)

I would like to think that as we approach the millennium the profession is in good heart both nationally and internationally to face the challenge of the next century. It is my belief that the profession is ready for change and capable of taking a lead role in the management of that change in our health care systems. In my professional education I was taught the importance of the pause or period for recovery between periods of maximal activity. We all need of to reflect on the part we can play in effecting the changes we know to be necessary.

We started with Molly Levy and perhaps it is appropriate to finish with her, that is, to emulate the example of her faith in the profession of physiotherapy, to match her dedication to it and like her, find the general goodness within ourselves to drive the changes necessary for its survival.

On behalf of the World Confederation for Physical Therapy I salute the past achievements of the South African Society of Physiotherapy, I congratulate you for the evidence of your present excellence and I look forward with confidence to your future health in partnership with your colleagues throughout the world.