AN EXPLORATION OF ETHICAL ISSUES ENCOUNTERED BY PHYSIOTHERAPY PRACTITIONERS IN LUSAKA, ZAMBIA IN MANAGING PATIENTS WITH LOW BACK PAIN

By

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DECLARATION

I Kangwa M Chileshe, Know that use of another's work and presenting it as my own is a criminal offence. Each significant quotation from the work/s of others has been sited and attributed as such.

I declare that the work in this paper is my own. I have not allowed and will not allow anyone to copy my work with an intention of presenting it as their own.

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CERTIFICATE OF APPROVAL

This dissertation of Kangwa M. Chileshe has been approved as partial fulfilment of the requirements for the award of the degree of Master of Science in Physiotherapy – Orthopaedics by the University of Zambia.

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ABSTRACT

Introduction: Management of patients with Low Back Pain (LBP) may raise ethical issues in physiotherapy clinical practice that may affect practitioners' efficiency and effectiveness in healthcare delivery. The aim of this study was to explore and provide additional insight into the nature and scope of ethical issues and dilemmas encountered by physiotherapy practitioners in Lusaka. Furthermore, the study aimed to determine whether physiotherapy practitioners were adequately prepared in training to handle ethical issues encountered in clinical practice.

Methodology: An exploratory mixed method study design was used. The study captured 66 physiotherapy practitioners working in Lusaka district. The qualitative method had 16 participants in two Focus Group Discussions (FGDs), which were analyzed according to the principle of Giorgi's phenomenological analysis. Quantitative data collected through a structured questionnaire was analyzed using descriptive statistics. Triangulation was done by comparing and combining insights from both qualitative and quantitative data which increased the reliability of findings. Ethical approval was obtained from ERES-Converge Research Ethics Committee.

Results: Both study methods revealed that practitioners had difficulties in handling conflict of culture and treatment process; Patient/Physiotherapy practitioner relationships; Communication; and dilemmas of practice. Most respondents agreed that they were adequately prepared in training to handle ethical issues even though 62% in the quantitative component indicated that they would benefit from further training in clinical ethics.

Conclusion: Outcomes highlight that physiotherapy practitioners encounter ethical issues in the management of patients with LBP. Majority had difficulties in handling the ethical issues raised.

Recommendations: Emphasis on ethical decision-making skills; sensitisation workshops/seminars on good Standards of Practice; and further research on ethical issues raised in this study is recommended

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DEDICATION

I dedicate this work to my children Themba, Kanyanta and Kale. You are a precious gift from God. You give me courage, strength and a reason to persevere in life.

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LIST OF ABBREVIATIONS

AGM	Annual General Meeting
APTA	American Physical Therapy Association
CPA	Canadian Physiotherapy Association
CHCH	Chainama Hills College Hospital
EHC	Evelyn Hone College
ER-WCPT	European Region - World Confederation for Physical Therapy
FGDs	Focus Group Discussion
HPCZ	Health Professions Council of Zambia
LBP	Low back pain
LMGH	Levy Mwanawasa General Hospital
MOH	Ministry of Health
MSDs	Musculoskeletal diseases
UTH	University Teaching Hospital
UNZA	University of Zambia
WCPT	World Confederation for Physical Therapy
ZIOH	Zambia Italian Orthopaedic Hospital
ZSP	Zambia Society for Physiotherapy

GLOSSARY OF TERMS

Physiotherapy

According to the World Confederation for Physical Therapy (WCPT), "Physical Therapy is a health profession which provides services to people and populations to develop maintain and restore maximum movement and functional ability throughout the lifespan".

Physiotherapy Practitioner

The primary physiotherapy practitioners are physiotherapists. Physiotherapists are holders of a minimum of a bachelor's degree and licensed professionals concerned with the remediation of impairments and disabilities and the promotion of mobility, functional ability, quality of life and movement potential through examination, evaluation, diagnosis and physical intervention (WCPT 2011). The Health Professions Council of Zambia (HPCZ), registers physiotherapists and diploma holders who are called physiotherapy technologist (HPCZ register 2012). In this study physiotherapy practitioners will mean physiotherapists and physiotherapy technologists.

Professional Ethics

This is a collection of criteria, rules and moral values that are formulated and assumed by a profession. To practice the profession of physiotherapy, the WCPT has established eight ethic principles that are expected to be observed by the physiotherapy practitioners (WCPT 2007).

Code of Ethics

Codes of practice/ethics are ethical rules and principles that form an obligatory part of professional practice. They may be established by the physiotherapy profession or incorporated into national rules and laws (ER-WCPT 2010).

Ethical Issues

An ethical issue is a situation where one has to judge what is right or wrong, choose between options, deciding whether to do something or do nothing, or weighing up the potential impact of your decisions or actions (Beauchamp & Childress 2001).

Ethical dilemmas

Bioethics literature defines ethical dilemmas in terms of conflict and choice between values, beliefs and options for action (Braunack-Mayer 2001). Ethical dilemmas Involve two or more morally correct courses of action where only one can be followed. In choosing one course of action over another the practitioner is doing something right and wrong at the same time (Beauchamp & Childress 2001).

Cultural competence

Set of congruent behaviours, attitudes and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations (ER-WCPT 2010).

Culture

'Culture' refers to integrated patterns of human behaviour that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. 'Competence' implies having the capacity to function effectively as an individual and as an organisation within the context of the cultural beliefs, behaviours and needs presented by consumers and their communities (APTA 2004).

Education Curriculum

A curriculum is the set of courses, and their content, offered at a school or university. A curriculum is prescriptive, and is based on a more general syllabus which merely

specifies what topics must be understood and to what level to achieve a particular standard (Kelly 2009).

Low Back Pain

Low back pain is generally defined as the perception of pain in the posterior aspect of the body between the inferior border of the rib cage and the inferior gluteal fold (Al-Eisa 2010 and Fritz et al., 2007).

CHAPTER ONE

INTRODUCTION

1.1 Background

Physiotherapy as a profession is governed by a professional Code of Ethics which provides guidance. However, these rules cannot offer definitive resolutions to all ethical questions and dilemmas that might arise during professional practice (CPA 2003). Praestegaard & Gard (2011) reported that in the course of the last four decades, physiotherapy has progressively expanded its scope of responsibility, focusing on professional autonomy and evidence-based clinical practice. Adding that to preserve professional autonomy it is crucial for the physiotherapy profession to meet society's expectations and demands of professional and ethical competences. The Zambia Society for Physiotherapy (ZSP) recently formulated its own Standard Code of Ethics (ZSP-AGM 2013) and like all member organisations, ZSP adheres to the World Confederation for Physical Therapy's (WCPT) laid down Code of Ethics.

Physiotherapy is an integral part of health promotion, prevention, acute care and rehabilitation of various diseases and injuries (Higgs et al., 2008). Musculoskeletal diseases (MSDs), particularly low back pain (LBP) are among the commonest conditions seen in physiotherapy practice (Fritz et al., 2007). The World Health Organisation (WHO) ranked MSDs in the top priority for global burden of disease and are the leading cause of long-term hospital visits and disability worldwide (Woolf & Pfleger 2010). The care process for patients with LBP involves assessment, physical diagnosis or problem summary, identification of client-centered goals (outcomes), selection of effective therapeutic interventions and evaluation of progress. Ethical issues may arise at any stage of this process, that is, from the first contact with the patient to the time the patient is discharged (Poulis 2007). Further, he described three distinctive ethical issues that emerge from clinical physiotherapy practice. First were the concerns of decision making about end-points in physiotherapy, a patient almost always can further improve with continuing physiotherapy intervention. Therefore, an appropriate end-point for treatment may not be clear and the person responsible for deciding when the end of treatment occurs may not always be the physiotherapy practitioner (Gibson et al., 2009; Flett & Stoffell 2003). Patients and other health care professionals play a

role in the discharge process and may hold different definitions of end goals in rehabilitation. Purtilo et al., (2005) defined these types of ethical issues as "locus of authority" problems.

Poulis (2007) also described concerns of the patient/therapist relationship which raises ethical issues surrounding recognition and maintenance of professional boundaries. Explaining that in physiotherapy treatments are often one-on-one interaction and physical contact, relying on touch, communication and advice. Hands-on techniques in physical examination and manipulation treatment techniques are often employed (Southorn 2010). In addition, the physiotherapy practitioner meets with the patient for a course of treatment of about ten or more sessions in a month, and since a physiotherapy practitioner must continually assess the patient, the degree of communication between the patient and his/her therapist is quite high in order to achieve successful rehabilitation. Baker & Stiller (2006) also explained that patients with chronic illnesses relying on long term physiotherapy to improve their quality of life often develop a dependency on their therapists. By the nature of their role, physiotherapy practitioners frequently develop a close physical relationship and an emotional attachment with their patients that is often unique within the healthcare (Cooper & Jenkins 2008). Recognition and maintenance of professional boundaries becomes a challenge. If or when a patient/therapist physical attraction occurs, the question that arises is whether to continue therapy despite the patent's/physiotherapy practitioner's discomfort, discharge the patient prematurely, or refer to another practitioner. Will the patient receive the same quality of care (Cooper & Jenkins 2008)? What happens to the rights of the patient to receive healthcare regardless of indifferences as stated by World Confederation of Physiotherapists (WCPT)?

Furthermore, Poulis (2007) highlighted the requirement for active participation of the patient and its impact on the patient/therapist relationship. In physiotherapy, a patient's trust must extend beyond accepting and believing in advice and treatment suggestions to a willingness to actively participate and collaborate to achieve the physical and functional goals set by his or her therapist (Delany et al., 2010). According to McLean et al., (2010), patients are given exercise programmes to follow at home with no professional supervision. The questions that arise are: Can the physiotherapy practitioner be sure that the patient is doing the correct pattern of exercise? Who is responsible for effective rehabilitation, the patient, the caregiver or the professional?

Other areas of ethical conflict include culture, confidentiality, and informed consent, cost-effectiveness of treatment and skill of physiotherapy practitioners (Carpenter & Richardson 2008). 'Culture includes, but is not restricted to: age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability' (Tinana 2004). Furthermore, to be culturally safe there should be no discrimination and that behaviour ensures that staff and patients are valued, respected and included in decision making. What than happens when the physiotherapy practitioner's and patient's cultures are in conflict? Questions are raised on how much information physiotherapists give their patients and whether patients actually consent to treatment. According to the Chartered Society for Physiotherapist's (2002) rules of professional conduct, the mere presence of the patient for treatment does not imply consent to treatment. It further states that patients deserve to know the truth about their condition and treatment, participate in decision-making, refuse to be used for teaching, and be given full care even when their choice differs from that of the physiotherapy practitioner. It is important to note that care for patients in physiotherapy should be based on sound judgement and evidence based practice. Ethical issues arise on whether the treatment administered is cost effective, evidence based or whether the physiotherapy practitioner has the required skill to manage LBP effectively.

This study set out to explore the ethical issues and dilemmas encountered by physiotherapy practitioners in clinical practice particularly in the management of low back pain. The study aimed at providing additional insight into the nature and scope of ethical issues and dilemmas as they were understood and experienced by physiotherapy practitioners in Lusaka. The study further set out to establish whether the physiotherapy practitioners were prepared to handle ethical issues encountered in their everyday clinical practice.

1.2 Statement of the Problem

Physiotherapy practitioners often face ethical issues and dilemmas that affect their efficiency and effectiveness in healthcare delivery. Swisher (2002) reported that leaders within physiotherapy had repeatedly noted that increased autonomy had brought more complex ethical issues, dilemmas and responsibility. Physiotherapy practitioners recognise that individuals with injuries or disabilities provide special challenges because of their increased vulnerability within the general population. Although practitioners understand the need to

make ethically based clinical decisions, their decision making skills have not been examined (Kirch 2010). It is important to note that Cultural values, evidence based practice and skill of practitioners is cardinal to biomedical ethics (Beauchamp & Childress 2001).

The chronic nature of most of the conditions managed in physiotherapy such as LBP entails prolonged visitations to physiotherapy. In the Department of Physiotherapy at UTH, 32% of appointments from 2011-2012 were back pain related, 40% of the patients in the first half of 2012 were being treated for back pain and most of these patients had been attending physiotherapy sessions for more than three months (UTH records 2012). The characteristics of managing LBP involve assessment and treatment procedures which require exposure of the back to the level of the buttock and hands-on procedures of palpations and manipulations (Southorn 2010). In most African cultures including Zambia, exposure of certain parts of the body is a sensitive issue and the mere mention of LBP may be a taboo therefore, has to be handled with caution. Often, patients cannot choose who they want as a healthcare provider, therefore are vulnerable to variations in care and to potential exploitation, and the result of poor behaviour on the part of the practitioner can have dire consequences (Barnett et al., 2005).

Physiotherapy practitioners managing patients with LBP have found themselves handling marital problems relating to sexual function, through counselling and advice, a skill that they may not be competent in. This is supported by Kamau (2005) who reported that some patients with LBP face problems with sexual function, and were of the opinion that their spouses needed to be given some counselling and advice to understand back problem.

The primary goal of physiotherapy is to provide the highest quality of care to achieve the best outcomes for patients in a cost-effective manner. In order to achieve this goal, clinical practice must be evidence based. However, the effectiveness of physiotherapeutic interventions used for LBP continues to be a matter of much debate with many currently used interventions not having been substantiated by research evidence (Pensri et al., 2005). While research in approaches to LBP management in developed countries has increased, little is known about LBP management in developing countries (Pensri et al., 2005). In Zambia, LBP treatment approaches depend on practitioner's academic knowledge, available equipment and work experience.

1.3 Justification

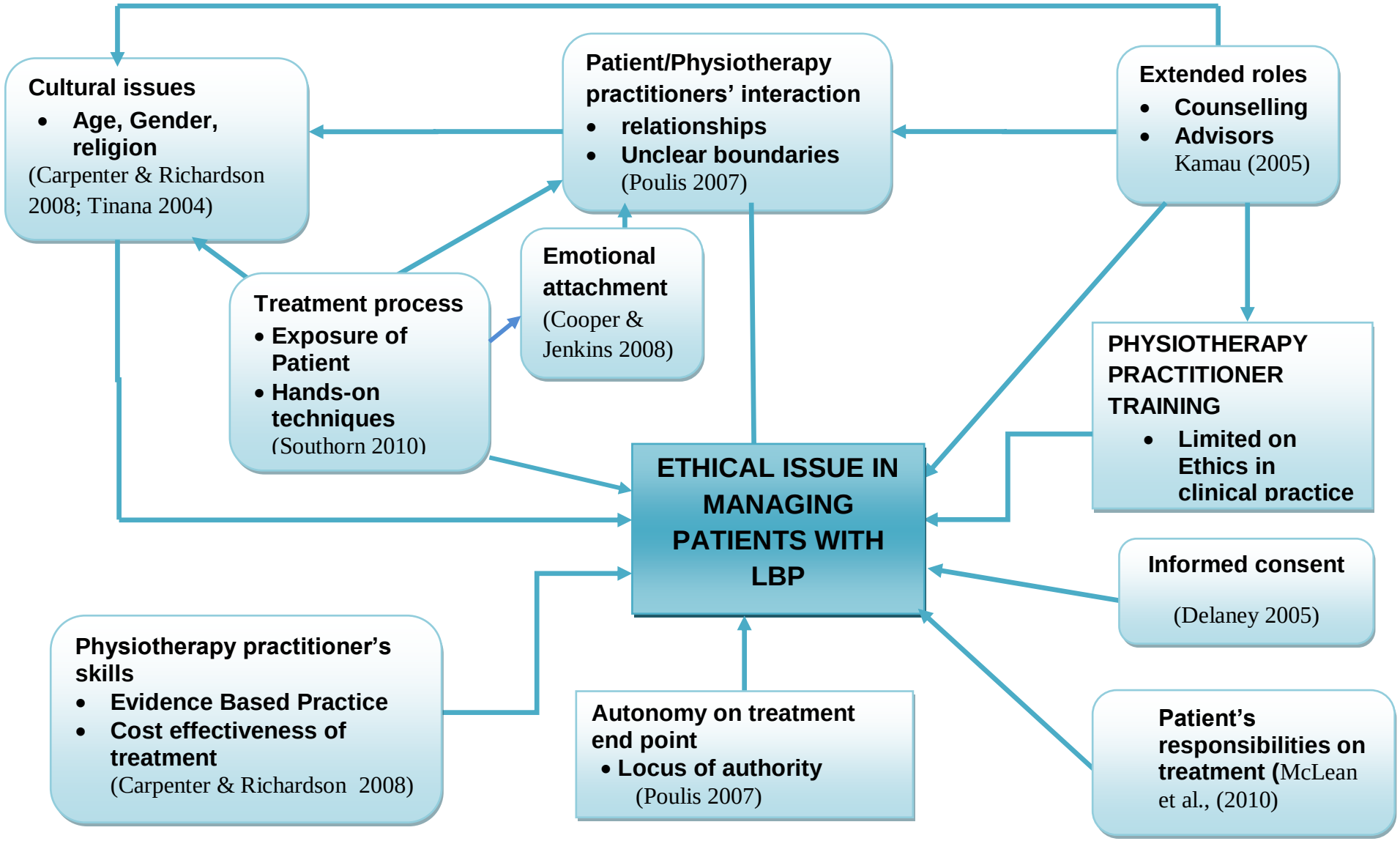
There is scanty information on ethical issues encountered in specific areas of physiotherapy practice including the physiotherapy management of patient with LBP. The researcher could not find any published articles on ethics of practice among Zambian physiotherapy practitioners. The aim of this study was to identify ethical issues and dilemmas encountered by physiotherapy practitioners in the management of patients with LBP and the factors which influence these issues. Also to explore the physiotherapy practitioners' opinions on their preparedness in training, to handle ethical issues encountered in everyday clinical practise. The study aims to add to the body of knowledge on ethics in physiotherapy clinical practice and stimulate further research. Recommendations from the study will inform physiotherapy trainers.

1.4 Conceptual framework

The conceptual framework of the study outlines the statement of the problem and how it relates to the research questions that arose from the observed challenges of ethical issues encountered in managing patients with LBP. The research questions and statement of the problem have been guided by literature review as elaborated in the study background and literature review section; with the view of establishing the ethical issues encountered in managing LBP and physiotherapy practitioner's preparedness in their basic training in handling these issues.

As shown in figure 1.1 ethical issues encountered in general physiotherapy practice and those observed in managing patients with LBP are outlined. The training of physiotherapy practitioners at basic levels, that is, diploma and degree level, on ethics in clinical practice is also noted as a challenge.

Figure 1.1: Diagram of conceptual framework



1.5 Research Questions

i). What ethical issues do physiotherapy practitioners' in Lusaka, face in managing patients with low back pain?

ii). Did physiotherapy practitioners get adequate training in handling ethical issues and dilemmas encountered in managing LBP patients when they were undergoing training as students?

1.6 General Objective

To explore the ethical issues encountered by physiotherapy practitioners in managing patients with low back pain.

1.7 Specific Objectives

1.7.1 To identify ethical issues and dilemmas faced by physiotherapy practitioners in managing patients with LBP.

1.7.2 To determine whether the physiotherapy training adequately prepares physiotherapy practitioners to face ethical issues encountered in clinical practice.

1.7.3 To establish whether physiotherapy practitioners require additional training in handling ethical matters faced in clinical practice.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Physiotherapy is an evolving profession and there is currently great change in the health and social care sector with a continuous drive towards excellence and consistence in clinical practice (CSP- CSPP 2005). In recent years, physiotherapy has evolved dramatically, to the point where it is now a major healthcare profession offering assessment, diagnosis and treatment for a wide range of conditions, from sports injuries to rehabilitation for major injuries and diseases (Cameron & Michelle 2003 and Poulis 2007). This change has brought about challenges in service delivery that border on ethical competences. According to Kirch (2010), there has been an increase in awareness on ethics in the physiotherapy profession but not much attention has been given to ethical decision making skills of physiotherapy practitioners. This chapter will look at Physiotherapy knowledge on Clinical ethics; Physiotherapy training on clinical ethics; Management of low back pain in physiotherapy; and Ethical decision-making and the principles of clinical ethics.

2.2 Physiotherapy knowledge on Clinical Ethics.

In a systematic review on knowledge on ethics present in physiotherapy literature 1970 - 2000, Swisher (2002) concluded that very few studies, attempted to define ethical issues physiotherapists face routinely in practice. In a follow-up, Carpenter & Richardson (2008) reviewed publications between the year 2000 – 2007 and revealed a partial closing of the gap between theory and practice This was attributed to an increase in research about the "unique ethical issues encountered in physical therapy practice, factors that affect ethical action, the role of the physical therapists as a moral agent and the types of moral reasoning being used by physical therapists in practice**.** However, Carpenter & Richardson (2008) highlighted ongoing gaps in research about factors that influence everyday ethical decision making within specific contexts of physical therapist practice and recommended more research on cultural dimensions of ethical practice, patient's perspectives on ethical practice and how the institutional setting affect the role of the physical therapist as a moral agent.

Praestegaard (2001), in an interview study of 17 physiotherapists concluded that Danish physiotherapists were interested in the ethical dimension of physiotherapy but not

consciously aware of when, why or how often ethical issues occurred in practice. This low degree of awareness led to several immoral and sometimes even illegal actions. Carpenter et al., (2008) reported that the impact of institutional environment on generating ethical issues and on practitioners' management of these issues needed more systematic investigations. Delany & Frawley (2012), reported on ethical dilemmas of peer physical examination in pelvic floor physiotherapy practice among Australian students. The two authors raised the issue of how students could feel pressurised to participate despite their own discomfort and embarrassment.

A survey by Barnitt (1998) on ethical dilemmas in Occupational Therapy and Physical Therapy in the United Kingdom revealed that 102 physiotherapy respondents reported four main clinical specialities where most ethical dilemmas occurred. These were orthopaedic, neurology, respiratory, and surgery units; citing issues of unfair allocation/lack of resources, treatment appropriateness/effectiveness, unprofessional/incompetent staff, not telling the truth, lack of respect for the therapists' opinions, and difficult patients.

2.3 Physiotherapy training in Clinical Ethics

The training institutions that currently offer physiotherapy in Zambia, University of Zambia (UNZA) and Evelyn Hone College (EHC) have topics on ethics in the fourth and second year respectively. In the curriculum for Bachelor of Science Degree in physiotherapy at UNZA School of Medicine (2007), topics relating to ethics in clinical practice are covered in the course - Professional Practice. These are: Treatment and Communication which cover the following; explanation of treatment procedures, giving instructions, giving encouragement and advice, and problems with patients/personality clash. Patient presentation which cover the ethical and professional clinical presentation of patients

In the EHC curriculum for diploma in physiotherapy (2005), topics relating to ethics in clinical practice are covered in the course – Professional Orientation, Ethics and Management. Topics are; Applying physiotherapy principles covering physiotherapy examination, and displaying professional conduct and behaviour covering fundamentals of ethics in health care, personal appearance and behaviour.

2.4 Management of low back pain in physiotherapy.

Low back pain is considered a major health problem due to its high prevalence, high probability of recurrence, and associated disability (Al-Eisa 2010). According to Pensri et al., (2005), physiotherapy is considered to play an important role in the management of patients with LBP. Various studies of clinical practice in developed countries have revealed that the most common LBP treatment approaches include Maitland mobilization, the McKenzie approach, exercises, advice and electrotherapeutic modalities. However, in developing countries, little is documented on LBP management (Pensri et al., 2005), At the UTH which is the main training institution for physiotherapy clinical practice in Zambia, management of LBP involves mostly massage therapy, exercises, advice and electrotherapeutic modalities. This is preceded by an introduction, subjective assessment and physical examination (UTH records 2012).

2.5 Ethical decision-making

Ethical decision-making involves the skill of discernment of a situation and balancing this against one's moral beliefs or principles (Iyalomhe 2009). Resolving the dilemma requires the ability to recognize and interpret situations or sensitivity, and ability to make decisions about right or wrong and determining a course of action or judgment (Oyeyemi 2011). Further stating that ethical decision-making also requires the ability to place ethical values before other values or motivations, and the discipline or moral courage to persevere against adversity.

2.5.1 Principles of clinical ethics

The traditional ethical principles that guide the professional in evaluating situations and making decisions are; respect for autonomy, beneficence, non-maleficence and justice (Dalany 2010). In physiotherapy, and other health fields, veracity and fidelity are also spoken of as ethical principals but they are not part of the foundational ethical principles identified by bioethicists (Kirch 2010).

2.5.1.1 The Principle of Autonomy

Respect for autonomy requires that patients be told the truth about their condition and informed about the risk and benefits of treatment (Kirch 2010). Furthermore, patients are

permitted to refuse treatment even if the best and most reliable information indicates that treatment would be beneficial, unless their action may have a negative impact on the well-being of another individual. These conflicts set the stage for ethical dilemmas. According to Veatch (2003) healthcare is at its foundation a partnership between the provider and the recipient of care. Each owes the other responsibility and respect.

2.5.1.2 The Principle of Beneficence

Beneficence is the act of being kind and providing care that is in the best interest of the patient. Traditionally the decision making process and the ultimate decision were the purview of the physician. This is no longer the case; the patient and other healthcare providers, according to their specific expertise, are central to the decision-making process (Valente 2000).

2.5.1.3 The Principle of Non - maleficence

According to Kirch (2009), non - maleficence means doing no harm; therapists must ask themselves whether their actions may harm the patient either by omission or commission. The guiding principle of *primum non nocere,* "first of all, do no harm," is based in the Hippocratic Oath. Furthermore, actions or practices of a healthcare provider are "right" as long as they are in the interest of the patient and avoid negative consequences.

2.5.1.4 The Principle of Justice

Justice speaks to equity and fairness in treatment. Ethical theory today must extend beyond individuals to the institutional and societal realms (Gabard & Martin 2003). Justice may be seen as having two types: distributive and comparative. Distributive justice addresses the degree to which healthcare services are distributed equitably throughout society. Beauchamp and Childress (2001) identify six material principles that must be considered, while recognizing that there is little likelihood all six principles could be satisfied at the same time. These principles are;

1. To each person an equal share.
2. To each person according to need.
3. To each person according to effort.
4. To each person according to contribution.

5. To each person according to merit
6. To each person according to free market exchange

Comparative justice determines how healthcare is delivered at the individual level. It looks at disparate treatment of patients on the basis of age, disability, gender, race, ethnicity, and religion. Of particular interest currently are the disparities that occur because of age.

Veracity and fidelity are not foundational bioethical principle but are included in ethics texts. Veracity or truthfulness is at its core an element of respect for persons (Gabard 2003). Veracity forms the basis for the autonomy expected by patients today. Informed consent, for example, is the ability to exercise autonomy with knowledge. Fidelity is loyalty focusing on keeping a promise, or being true to your word. Both patient and therapists owes the other loyalty; although the greater burden is on the medical provider (Beauchamp & Childress 2001). Fidelity often results in a dilemma, because a commitment made to a patient may not result in the best outcome for that patient (Veatch 2003).

2.6 Conclusion

Many studies have talked about the management of LBP relating to treatment procedures, classification and patient satisfaction with treatment. But not much has been done on ethical issues that occur during delivery of physiotherapy services to patients with LBP. It is apparent that principles of clinical ethics do conflict in many circumstances of heath delivery. When good patient care demands more than the system has allocated, there may be a need for adjustments.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter will give a description of the, study design, research setting, study population, inclusion criteria and exclusion criteria. Two research methods were used, namely qualitative and quantitative methods. Each research method will be explained separately under subheadings, detailing pilot study. sampling method, data collection, instruments, data capturing and data analysis. Finally, the ethical aspects which were considered in the study will be stated.

3.2 Study Design

An exploratory study design utilizing a combination of the qualitative and quantitative methods was used. This mixed method was used in order to bring together the benefits of both qualitative and quantitative approaches to this research, therefore strengthening the methodology of the study and making the results more reliable (Tashakkori & Teddlie 2010). The qualitative method employed focus group discussions (FGDs) which were aimed at gaining insight into the nature and scope of ethical issues encountered by physiotherapy practitioners managing patients with LBP, and opinions on clinical ethics training. This addressed the objectives of the study. The quantitative method also addressed the objectives of the study using a structured questionnaire to give numerical value to the findings.

3.3 Research Setting

This study was conducted at both government and private health institutions in Lusaka which have physiotherapy practitioners. Lusaka district was established in 1905 and is the capital and largest city of Zambia. According to the Central Statistical Office records, in 2010 the population of Lusaka was approximately 3.1 million and the population density in Lusaka stood at 44,285. 7 per square kilometre. As a national capital, Lusaka is a commercial centre as well as the centre of government and seats the legislative, executive and judicial branches of government. This study setting was selected purposive because Lusaka accounted for a larger population of physiotherapy practitioners in one district compared to other districts. According to the Health Professions Council of Zambia record (2012), there were 485

registered physiotherapy practitioners in Zambia and 92 (20%) were practicing in Lusaka district in both government, non-governmental organizations' health facilities and private institutions. Lusaka enabled easy accessibility to participants as they were found within one town, given the limited time in which to conduct the study.

The study setting for the qualitative part was purposefully selected and consisted of two hospitals namely UTH and Levy Mwanawasa Hospitals (LMGH). The UTH is a tertiary hospital which handles referrals from the whole country. While LMGH is a general hospital, handles referrals from the whole district. Therefore, practitioners in these institutions are exposed to patients with different social/cultural backgrounds. Furthermore, UTH and LMGH have a larger physiotherapy staffing compared to other institutions. This made it easier for the researcher to meet the targeted numbers for the focus groups.

3.4 Study Population

The study population consisted of physiotherapy practitioners working in Lusaka district.

3.5 Inclusion Criteria

The study included practicing physiotherapy practitioners in Lusaka. The participants had consented to participate in the study and had worked for at least one year.

3.6 Exclusion Criteria

This study excluded participants who had not consented to taking part in the study and candidates who had worked for less than one year.

3.7 Part One of Study: Qualitative Component

This part of the study will explain the qualitative research method that was used.

3.7.1 Pilot Study

A pilot study for the qualitative study was conducted among physiotherapy practitioners at Kabwe General Hospital and Kabwe Mine Hospital. Kabwe was selected because it was easily accessible for the researcher and the actual study was not conducted in this district.

One FGD was conducted; based on this pilot study the researcher was able to adjust questions on the discussion schedule, estimate duration of discussion and refine the themes.

3.7.2 Sampling method

A purposive sampling method was used to select eight participants for each focus group. According to Krueger (2006) focus groups generally work best with 8-12 participants. The researcher selected physiotherapy practitioners who had been treating patients with low back pain and had consented to participant in the FGDs.

3.7.3 Data Collection Instrument and Procedure

Two focus groups were constituted, the first one (Group 'A') at UTH and the second one (Group 'B') at (LMGH), with physiotherapy practitioners from the said hospitals. Data was collected through a tape recorder and note taking for non-verbal communication in FGDs. Permission was sought to conduct FGDs at UTH and LMGH department of physiotherapy (Appendix V1 page 70). Information sheets (Appendix I page 59) and consent forms (Appendix III page 60) were hand delivered to participants at UTH and LMGH prior to the discussions. The participants who consented to take part in the study were sampled into the respective focus groups. The tape recorded FGDs were guided using open ended questions (appendix 1V page 62). During the discussions no participant was called by name, instead identity codes were used. Focus group 'A' had code names A1 to A8 while focus group 'B' had code names B1 to B8. Viewpoints expressed were coded according to their frequency and relevance to the questions, grouped into themes and presented verbatim. Prior to the discussion, each participant answered a short questionnaire to gather demographic data.

3.7.4 Data Analysis Method

All focus group discussions were analysed according to the principle of Giorgi's phenomenological analysis, modified by Malterud (2001). This method was suitable for this type of study. According to Malterud (2001), Giorgi's analysis is based on phenomenological philosophy and is suited for development of descriptions and notions related to human experience. The analysis followed four steps:

1. Audio tapes were transcribed and the viewpoints expressed were coded according to their frequency and relevance to the questions. The coded viewpoints were then grouped into themes and presented in verbatim
2. Re-reading the transcripts and listening to the recording of the discussions to discriminate units with meaning from an ethical perspective.
3. Content of meaningful units were collected within each theme.
4. Transformed themes were synthesised into a consistent statement regarding the participant's experience. Finally the themes were given a conclusive headline.

The themes which were generated from the two focus groups 'A' and 'B' were then combined through thematic analysis.

3.7.5 Trustworthiness

In qualitative research reliability and validity are conceptualized as trustworthiness, rigor and quality in qualitative paradigm (Golafshani 2003). Further he defines reliability as the ability of an instrument to yield the same results each time it is used. On the other hand, Jopp (2000) explained that validity determines whether the research truly measures that which it was intended to measure or how truthful the research results are. In this study the credibility (in preference to internal validity) and dependability (in preference to reliability) of the results was done through independent verification and In-depth methodological description to allow study to be repeated, this is supported by Shenton (2003). According to Hycner (1985) independent verification is a helpful reliability check for qualitative research. Therefore, a specialist in qualitative research was engaged to independently carry out the qualitative data analysis and verified the research findings, and further upheld the rigor of the study. The research supervisor who is also an expert in Bioethics also verified the findings.

3.8 Part Two of the Study: Quantitative Component

This part of the study will explain the quantitative research method that was used.

3.8.1 Sampling method

The researcher aimed to have a census of the remaining 76 physiotherapy practitioners since the population was small**.** However, only fifty participants who were available in their

stations responded to the questioner. These were from the following institutions; Government hospitals – UTH (15), LMGH (3), Chainama Hills College Hospital (2), Maina Soko Military Hospital (5); and clinics - Chilenje (4), Chawama (2), Kanyama (2), George (1), Chingwere (2), and Mutendere (2). Private hospitals - Zambia Italian Orthopaedic Hospital (6), Beit Cure trust (3), MKP hospital (2) and Cheshire Homes Kabulonga (1). Yount (2006) emphasises that in quantitative research, a census is advisable when study population is less than 100 because when methods are used to calculate sample size the value is almost equal to that of the population.

3.8.2 Data Collection Instrument and Procedure

A structured questionnaire (Appendix V page 64) was developed specifically for this study. This questionnaire was refined based on the findings of the qualitative component. The use of a questionnaire allows every participant to get a similar assessing tool to complete which resulted in standardized responses (Burns 2000).

Information sheets (Appendix II page 60) and consent forms (Appendix III page 61) were hand delivered to physiotherapy practitioners in all the said study settings. A structured questionnaire (Appendix V page 64) was also hand delivered to participants who had consented to take part in the study and had not taken part in the FGDs.

3.8.3 Development of the Questionnaire

The questionnaire (appendix V page 64) consisted of three sections. Section ‘A’ questions 1 to 9 - Demographic Data described the characteristics of the participants such as age, gender, religion and academic qualification. Section ‘B’ questions 10 to 29 - focused on different dimensions of ethical Issues; aiming at identifying the nature of ethical issue encountered by practitioners, factors influencing ethical issues and how practitioners found handling these ethical issues. Section ‘C’ questions 30 to 32 – aimed at determining whether the physiotherapy training adequately prepared physiotherapy practitioners to face ethical issues encountered in clinical practice. This questionnaire was structured and refined before use based on the finding of the FGDs in the qualitative method.

The questionnaire was pre-test among the researchers’ peers and some questions were adjusted.

3.8.4 Data Capturing

The quantitative data was captured utilizing the SPSS (Statistical Package for the Social Sciences) software version 18.0 for windows, for the analysis after conversion of the responses from nominal to numerical format. Demographic data was assigned numerical codes while questions on experiences of ethical issues given a 'yes' or 'no' response were coded 1 and 2 respectively. Vagias & Wade (2006) Likert-type scale was used to measure the levels of agreement on preparation in training to handle ethical issues (strongly disagree –1, disagree -2, neither agree nor disagree –3, agree –4, strongly agree -5.)**,** and level of difficulty in handling ethical issues (very difficult -1, difficult -2, neutral -3, easy -4, very easy -5).

3.8.5 Data Analysis Methods

Data was analysed principally by means of descriptive statistics and summarised using percentages using SPSS. Each question was analysed separately and results presented using frequency tables and graphs**.**

3.9 Triangulation

Data collected from the qualitative and quantitative research methods, and Information from literature review was then triangulated. Triangulation strengthens both qualitative and quantitative analyses by combining insights from both research methods, therefore increasing its reliability (De Vos 2001). Tashakori & Teddlie (2010) pointed out that when both qualitative and quantitative methods are used they may result in uncovering some unique information that could have been omitted using one method. The authors further indicated that this combined method can increase the confidence in results and allow for creative methods.

3.10 Ethical Considerations

Ethical clearance and approval was sought from ERES-Converge Research Ethics Committee. Permission to carry out the study among physiotherapy practitioners was sought from the Ministry of Health (MOH), and UTH & LMGH to conduct FGDs in these institutions.

Information that was collected from participants was treated in strict confidence and participants remained anonymous in reports or publications that have emanate from their participation in this study. Verbal and written consent was obtained from FGDs participants to record the discussion and their names were not identified. Numbers were instead used to identify speakers during the discussions. The recorded date was used only for the purpose of this research and was later deleted**.** Participants who read the information sheets for the study (Appendix I page 59 & II page 60) and consented to take part in this study were asked to sign consent forms (Appendix III page 61). This, however, did not at any time supersede their will to withdraw from participating without being compelled to indicate reasons for their decision.

The results of the study will be disseminated to the Department of physiotherapy at UNZA and EHC, and to the MOH and Lusaka District Health Management Board.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the results of the study. The results from the qualitative and quantitative components are described and interpreted separately. Qualitative data results are presented verbatim under subheadings and themes while the quantitative data, and results presented with the aid of tables and graphs under subheadings and themes.

4.2 Part One of Study: Qualitative Component

4.2.1 Socio-demographic characteristics of the participants

A total of sixteen participants took part in the FGDs, and each group (Groups A and B) comprised eight members. All participants were Zambian and of Christian religion. Table 4.1 highlights the participant's social demographic characteristics.

Table 4.1: Socio-demographic characteristics of participants

Variable	Focus group A	Focus group B
Gender		
Male	2	2
Female	6	6
Age- years		
20-24	-	1
25-35	5	5
36-45	3	2
Marital status		
Married	6	7
Single	2	1
Education levels		
Diploma EHC	6	5
Degree UNZA	2	3
Work experience		
1 - 5 years	4	4
6 - 10 years	3	1
11 - 15 years	1	3

4.2.2 Emerging themes from the focus group discussions

Five themes emerged from the FGDs and are presented in the table 4.2 under the specific objectives of the study. The first four themes addressed the first objective which was; to have insight in the ethical issues encountered in management of patients with LBP. The second and third objectives were; to explore whether the physiotherapy training adequately prepares physiotherapy practitioners to face ethical issues encountered in clinical practice, and whether physiotherapy practitioners require additional training in handling ethical matters faced in clinical practice. These were addressed under the same theme where the impact of ethical issues on physiotherapy practice was also expressed.

Table 4.2: Emerging themes from the FGDs presented under specific objectives.

	Specific objectives and Themes identified
1	To have insight in ethical issues encountered in management of patients with LBP • Conflict of culture and treatment process. • Patient/Physiotherapy practitioner relationships • Communication • Dilemmas encountered
2 3	To explore whether the physiotherapy training adequately prepares physiotherapy practitioners to face ethical issues encountered in clinical practice. To explore whether physiotherapy practitioners require additional training in handling ethical matters faced in clinical practice. • Impact of training on physiotherapy practitioners' abilities to deal with ethical issues - Impact of ethical issues on physiotherapy practice

4.2.2.1 Ethical issues encountered

Participants narrated their experiences in ethical issues encountered during their clinical practice. These experiences are described under themes: Conflict of culture and treatment process; Patient/Physiotherapy practitioner relationships; Communication; and Dilemmas encountered in management of LBP.

4.2.2.1.1 Conflict of culture and treatment process

The cultural values of the patients and practitioners raised conflicts with the management process of LBP. Most participants said that differences in age and gender with their patients brought challenges when it came to exposure of patient and physical contact during treatment. They narrated that older patients did not want to be treated by younger physiotherapy practitioners because the patients were required to undress and expose their lower back during treatment. Other patients were uncomfortable to undress and have a practitioner of the opposite sex touch their back during treatment. This was attributed to religious values and beliefs especially among Muslims and some Christian women.

"Patients refuse treatment because of the therapist's age, gender, and ethnicity."

"The Asian community mostly Muslims are usually selective with practitioners, preferring to be treated by one with the same gender; even some Christian ladies would prefer to be treated by fellow ladies"

Other encounters narrated with regard to age and gender revealed that some patients actually refused to be treated by practitioners they were not comfortable with. This issue was noted among both female and male patients.

"This older lady in her 50s found me in the clinic. She bluntly denied me to treat her, and asked for a lady therapist."

"The patient said he was more comfortable to be treated by a fellow man."
"Patient said I was too young for him to undress."

Most participants did not express any difficulty in treating their patients in regards to differences in age or gender except one participant who mentioned that she was uncomfortable treating male patients.

The treatment modalities used in management of LBP and some types of exercises also posed a challenge to participants, relating to traditional beliefs and society's perception. Some male participants narrated encounters where female patients would not feel comfortable to be treated by them (males) because it was against their culture. Massage therapy was a major issue with patients; participants said that in their observation, massage is usually associated with sexual arousal. In addition some types of exercise often used in managing LBP; particularly 'bridging' which involves lifting of the pelvis is also related to a sexual act.

"In my culture no other man is allowed to touch a woman's waist."
"Touch mostly massage is part of sexual arousal; *Elderly patient refused to do bridging and related it to a sexual act. Patient asked therapist to climb on top of him when asked to do bridging."*

Therefore, this exercise which is beneficial to back patients may be culturally unacceptable; patients may feel uncomfortable with lifting the pelvis.

When faced with such situations, participants reported that they either referred the patient to the desired physiotherapy practitioner or convinced the patient to accept treatment. In situations where differences in gender raised challenges in treatment, participants had to involve the patient's spouse or another health professional to help with the treatment under instructions**.**

"With some patients I would call my colleague to treat them for me; I try to explain to the patient that it's just treatment."
"I was the only physio there, so I called a nurse to help me with treatment or sit near while I treated a female patient; sometimes I would ask the patients to come with the husband for treatment."

4.2.2.1.2 Patient/Physiotherapy practitioner relationships

Ethical issues surrounding recognition and maintenance of professional boundaries were raised. Participants said that situations occurred several times where patients developed an emotional and physical attraction to them, or vice versa. This was attributed to; high frequency of contact with patients, misunderstanding treatment procedure, and personalisation of therapists.

Participants narrated experiences where patients proposed love to them. Others said some patients would make suggestive comments like ***"you look nice"*** while treating them; or even pretend to still be in pain, since pain is subjective, just so that they could continue seeing their physiotherapy practitioner. Participants felt that the frequency of contact with patients is very high; patients frequently attend physiotherapy sessions and are in constant contact with the practitioners. The rapport that practitioner creates with the patient leads to an attachment that can easily lead to or be mistaken for physical attraction. Some treatment procedures like electric stimulation on the lower back and touch in massage therapy, may be sexually

stimulating when applied on the lower back, and are usually misunderstood then patients become attached to their therapy practitioner.

"Patient phoned me and said she felt she had found a man when she saw me in the clinic. She was proposing and it was quite challenging."

"You put electrolytes on them, interferential; they would feel good there and start making advances at you"

"Patient left without treatment on a day I wasn't working because he said he just liked the way I massage."

Sometimes patients personalize therapists, where they would just want to be attended to by the same physiotherapy practitioner. They become attracted to that particular therapist and will attend physiotherapy sessions only for the purpose of having contact with him or her.

"This patient I have treated for 4 sessions even calls me to find out if I am at work before he comes for treatment"

On the other hand, some participants felt it was okay to have a relationship with their patient as long as it was after treatment, stating they are human and these attractions were natural. They further argued that one never knows where they meet their partner, some people have met in physiotherapy and gotten married. However, others strongly disagreed, saying that it is unethical to make advances at a patient.

"I fell in love with one patient but it was after the hospital arrangement."

"Professionally it is very wrong to make advances on the patient."

When asked how they handled these situations, some participants said they chose to ignore patient's sentiments or advances; avoid patient; or just refer the patient to another practitioner. This was because they felt that the patient was compromising the profession. Others chose to explain to patients that they were there for treatment only, and make it clear to their patients that they were married. Some participants said they had situations where they had to discontinue the treatment even before the patient gets better just to avoid them**.**

"I keep a low profile; the patient can see that I have refused."

"Continue treating patient and tell them that their proposal will be considered after discharge, so that they don't feel shy."

"I discontinued massage even if the patient still needed it because I saw the interest in me."

However, some participants said that handling these issues was difficult and still a challenge to them.

4.2.2.1.3 Communication

Communication raised issues of informed consent and ending treatment. Obtaining informed consent for treatment from a patient was an issue that had mixed opinions from participants. Initially participants insisted that the information given to patients when they come for treatment was adequate; insisting that patient where aware of reasons of referral to physiotherapy from their doctors. But later in the discussions, participants revealed that information given is not detailed because the specific diagnosis and effects of the treatment is not usually explained to the patient. This poor communication when obtaining consent for treatment was attributed to staffing level and work over-load,

"We assess patients when they come but don't fully explain the findings, treatment and the benefit."

"It's not always that you explain to patients because of reduced manpower; there is no time."

Discharging of patients from physiotherapy was another issue that was raised; some participants said that the final decision to end treatment had to be by the physiotherapy practitioner with some input from the patients. Other professions like the referring doctor had no say on the matter. However, in some cases, the relationship that the patients create with their practitioners was said to be a challenge. The practitioner would easily be convinced by patient's opinion on the stage of recovery and fail to discharge the patient.

"I make the final decision to discharge patient because I set my own goals to achieve."

"Patients create a personal relationship with therapists and they fail to discharges them."

4.2.2.1.4 Dilemmas encountered

Participants mentioned several dilemmas encountered in management of LBP. These are illustrated in table 4.3.

Table 4.3: Areas of dilemmas encountered

	Areas of dilemmas encountered
1.	Culture
2.	Over exposure by patients
3.	Extended role
4.	Recognising boundaries of accepting gifts
5.	Patients active involvement in their own treatment
6.	Adherence to therapy
7.	Personalisation of therapist
8.	Professional conflicts

Culture in relation to traditional norms and social aspects raised issues of physiotherapy practitioners'/patients' comfort with treatment process and consequently affecting the effectiveness of treatment. Participants said that some female patients wear traditional beads around the waist; this makes them uncomfortable to assess or treat the patient because they do not want to touch or even look at the beads. In trying to avoid touching the beads, practitioners may fail to access the exact point of pain and come up with the correct diagnosis.

"I was very uncomfortable treating a female patient who was wearing beads around waist and had to cover the beads."

One participant said that they once had to treat a male in-law; this made her very uncomfortable because traditionally touching an in-laws waist is considered a taboo. In another case a participant said they had to risk compromising treatment by involving another health profession to practice physiotherapy because the patient was not comfortable being attended to by a male physiotherapy practitioner. The participants said that they were aware that this action was not ethical but felt compelled to go against standard practice in order to help the patient and uphold customs.

"One woman hesitated for me to treat her and said that in her culture no other man is allowed to touch a woman's waist. So I called a nurse to help me treat her."

Over exposure by the patient was also a source of discomfort as reported by the participants. They said that patients had a notion that they had to undress in physiotherapy sessions. Patients would over expose themselves, undress to the pants despite receiving instructions to only expose the back. This made administering treatment difficult for the participants

especially with patients of the opposite sex because they were uncomfortable to touch the patient. A participant narrated that she once had to treat her boss who over exposed himself, she was very uncomfortable during the treatment.

"I have felt uncomfortable with patients of the opposite sex who over expose themselves, looking at the private part."

"When I went in the treatment cubicle my boss was in his pant, it was difficult for me to treat."

Extended roles; Participants mentioned that due to the nature of this condition that is LBP, sexual function was usually an associated problem. Participants said that in their observation, most persistent backache result from sexual activity. To solve this problem they have often had to involve themselves in their patient's personal lives through advice and counselling. Others expressed discomfort in giving advice and counselling elderly patients but felt compelled to do so because of their profession, saying.

"we ask patients to rest the back from sexual activity but in so doing we interfere with conjugal rights."

"Advising couples on sex in a home becomes a challenge when the couple is elderly. But you have to help them"

The other dilemma was **recognising boundaries of accepting gifts** from patients. Participants mentioned that there was a conflict of professional ethics with culture, where gifts are considered as a way of appreciating;

"the culture surrounding gifts is that when one is not given a gift they feel unappreciated." However, participants disagreed on which gifts were acceptable, with some feeling that accepting gifts can compromise the profession**.** While others argued that it's only unethical if the gift was solicited for, and further questioned each other saying one is not supposed to refuse a gift. When asked how they can identify a genuine gift of appreciation, participants said that one can see that the gift is not genuine, or ask the patient the reason for offering that gift. Some participants reported that they were forced to discharge or refer patients to another practitioner because they were uncomfortable with the gifts. In one encounter, a participant said he was forced to go on leave to avoid the patient when her frequent gifts started making him feel uncomfortable.

"You can see that the gift is not genuine; if patient says the gift is genuine then accept it."
"This patient started inviting me for beers, and buying shirts and trousers for me. After discharge, she came back next day complaining of severe pain, then offered another invitation for beer, so to avoid her, I decided to go on leave, that's how her backache went (stopped attending physiotherapy)*."*

The **patient's active involvement in their own treatment** also raises dilemmas in practice, such as unsupervised home programmes and lack of professional follow up through community based rehabilitation programmes, Participants said that they have to trust in feedback from caregivers or trust that patients are doing the correct things at home.

"In rehabilitation, work shifts from physiotherapist to patient directly, but if unsupervised, may not reach intended goals"

Adherence to therapy; Patients may adhere or may not adhere to therapy due to religious and traditional beliefs, Participants said that they cannot stop patients who want to concentrate on prayers or traditional healers instead of physiotherapy.

"Some patients will want to concentrate on prayer or traditional healers instead of coming to the hospital."

Personalization of physiotherapy practitioner; some patients insist on a particular physiotherapy practitioner to treat them, so much that the practitioner was unclear about the patient's intensions. In another incidence a participant said that a patient at private clinic threatened to go to another hospital if she was not available to massage him. In both cases participants said they were uncomfortable to treatment the patients because they felt the patients were not thinking of massage.

"Patient had heard stories that my massage is good, so he wanted me to touch his waist."

Another dilemma was the issue of **professional conflicts**. Participants revealed that some referring medical professions hesitate to consider physiotherapy practitioner's impression on patient's diagnosis hence delaying treatment,

"patient had destruction of lumbar spine on X ray, and doctors said it was nothing. It was difficult to convince them until after sometime they did some test and found that this patient actually had TB of the spine."

However participants were quick to mention that most of the time when such situations occur, they would find professional ways of convincing the other professions and discussions were mostly successful.

"Seventy five per cent (75%) of the discussions have proved productive; a few cases you end up in a heated debate."

4.2.2.2 Impact of ethical issues on physiotherapy practice

Participants felt that some ethical issues resulted in inadequate assessments, wrong diagnosis, lack of cooperation from patients, poor adherence to treatment, and wrong treatment. Inadequate assessment was related to issues of exposure and accessibility to affected areas; where some patients where said to be uncomfortable when asked to lift their leg during assessment; and where patients had beads or fresh tattoos around the back which limited the physiotherapy practitioner to palpate during assessment or touch in manipulative therapy. These issues of restricted access to the back lead to inadequate assessment and consequently wrong diagnosis.

"Would limit therapists to access patient's problems; May give wrong muscle grading because patient feels uncomfortable lifting leg."

Perceptions on treatment programmes also raised negative effect in relation to types of exercises prescribed to the patient especially those that involve lifting of legs or pelvis raised negative effect on physiotherapy practice they were not culturally acceptable and patients were embarrassed to do the exercises; this could result in wrong treatment Participants also said that if therapists overlook the patient's cultural beliefs, patients are not likely to fully cooperate with treatment.

"In active room (exercise room), patient may do wrong back exercises because they have wrong concept about them."

"Patient was not cooperative the day a younger physio had to treat him."

Participants said they understood the patients' need to uphold cultural norms and were therefore obliged to treat all patients despite their discomfort or reservations. While other participants had no problems with cultural issues saying that, they did not feel uncomfortable because they were trained to treat all patients.

"These are cultural beliefs so you just remain with no option but just to treat them even when you are not comfortable."

4.2.2.3 Impact of training on physiotherapy practitioners' abilities to deal with ethical issues.

Impact of training on physiotherapy practitioner's abilities to deal with ethical issues looked at physiotherapy's prior training and preparedness to handle ethical issues encountered in clinical practice. Participants disagreed on the issue of preparedness to deal with ethical issues, some felt that they were adequately prepared to handle all the ethical issues that they faced in their practice. They said that a course 'Professional Orientation and Ethics' undertaken in college, professional ethics and conduct was well tackled. Scenarios of ethical nature were presented and students were taught on how best to handle certain issues. While other participants argued that looking at the great challenges they faced as practitioners in the field pertaining to handling ethical issues, they could not say that they were adequately prepared in training. Further stating that usually when ethical issues arouse, practitioners would either use their initiative to deal with the issue; consult senior practitioners on issue; and/or have learnt how to deal with ethical issues through experience and other health worker like social worker. Participants also said that their training and understanding of science helped them to convince their patients that they were doing the correct assessment and treatment procedures. However, despite this training, practitioners would still be compelled to follow cultural norms.

"We were given scenarios at school so we were prepared."

"*Ethical issues have not been adequately handled in school because they cause great challenges to practitioners in the field."*

"Consult seniors they tell you that these things happen, you will know how to handle them"

Participants strongly agreed that they would all benefit from further training on ethics in clinical practise. They suggested that workshops or seminars should be arranged to tackle topics on decision making in tackling ethical issues; cultural beliefs in relation to management of LBP; and counselling skills.

"If we attended workshops or seminars on such ethical issues surrounding physiotherapy all that would be tackled"

4.3 Part Two of Study: Quantitative Component

4.3.1 Socio-demographic characteristics of the participants

The questionnaire had a total of fifty respondents, who were mostly females (66%), Zambians (88%), Christian religion (96%), and age range of 25-35 years (50%). Most respondents (70.2%) indicated that they had not received any additional training in clinical ethics. One respondent did not indicate their gender while three did not indicate whether they had received additional training in clinical ethics. These results are illustrated in table 4.4.

Table 4.4: Socio-demographic characteristics of participants

Variable	Frequency	Percent	Valid Percent
Age			
16-24 years	5	10.0	10.0
25-35 years	25	50.0	50.0
36-45 years	16	32.0	32.0
46-55 years	3	6.0	6.0
Over 55 years	1	2.0	2.0
Gender			
Male	16	32.0	32.7
Female	33	66.0	67.3
Marital Status			
Single	14	28.0	28.0
Married	33	66.0	66.0
Divorced	1	2/0	2/0
Widowed	2	4.0	4.0
Nationality			
Malaysia	1	2.0	2.0
Zambia	44	88.0	88.0
Unknown	5	10.0	10.0
Religion			
Christian	48	96.0	96.0
Muslim	1	2.0	2.0
Hindu	1	2.0	2.0
Work experience			
1-5years	21	42.0	42.0
6-10years	12	24.0	24.0
11-15years	9	18.0	18.0
16-20years	4	8.0	8.0
Over 21years	4	8.0	8.0
Highest Qualification			
Diploma	22	44.0	44.0
Degree	25	50.0	50.0
Masters	3	6.0	6.0
Additional Training in clinical Ethics			
Yes	14	28.0	29.8
No	33	66.0	70.2

4.3.2 Themes addressed

The themes that emerged from the FGDs were presented in a structured questionnaire. Each question was analysed and is interpreted separately using percentages, addressing the specific objectives of the study. The first objective was; to determine the ethical issues encountered in management of patients with LBP. The second and third objectives were; to determine whether the physiotherapy training adequately prepares physiotherapy practitioners to face ethical issues encountered in clinical practice, and establish whether physiotherapy practitioners require additional training in handling ethical matters faced in clinical practice.

4.3.2.1 Ethical issues encountered

4.3.2.1.1 Conflict of culture and treatment process

Most respondents (90%) were comfortable with treating patients of the opposite sex, including those older than them (88%). Respondents also stated that patients did not show any problem with the gender (78%) or age (60%) of physiotherapy practitioner managing their condition. Furthermore, 74% of the respondent indicated that LBP patients had no difficulties to expose the back during examination or treatment. Seventy percent and 66% of the respondents indicated that treatment modalities such as massage, electrotherapy electrical stimulation did not cause sexual arousal in some LBP patients. In addition, 66% of the respondents stated that LBP patients did not hesitate to do 'bridging' exercise (lifting of pelvis because they relate it to a sexual act. These results are shown in table 4.5

However, of the respondents who indicated experiencing either of the ethical issues relating to conflict of culture and LBP treatment process, only 6% expressed that it was very easy to handle these issues. Meanwhile other respondents (12%) found handling this issues difficult while. others (66%) were neutral on the matter. These results are shown in figure 4.2.

Table 4.5: Conflict of culture and LBP treatment process

Experience	Response	Frequency	Percent	Valid Percent
Differences in age & gender:				
• Uncomfortable when Treating LBP patients of the opposite Sex	Yes No	5 45	10.0 90.0	10.0 90.0
• Uncomfortable when treating LBP patients who are Older	Yes No	6 44	12.0 88.0	12.0 88.0
• LBP Patient Request to be treated by Another Physiotherapy Practitioner because of Gender	Yes No	11 39	22.0 78.0	22.0 78.0
• LBP Patient Request to be treated by Another Physiotherapy Practitioner because of Age	Yes No	20 30	40.0 60.0	40.0 60.0
Exposure: LBP patients have difficulties to expose the back during examination or treatment	Yes No	13 37	26.0 74.0	26.0 74.0
Treatment modalities:				
• Some treatments such as massage therapy, electrical stimulation causing sexual arousal in some LBP patients	Yes No	15 35	30.0 70.0	30.0 70.0
• Some LBP patients hesitate to do bridging because they relate it to a sexual act	Yes No	17 33	34.0 66.0	34.0 66.0

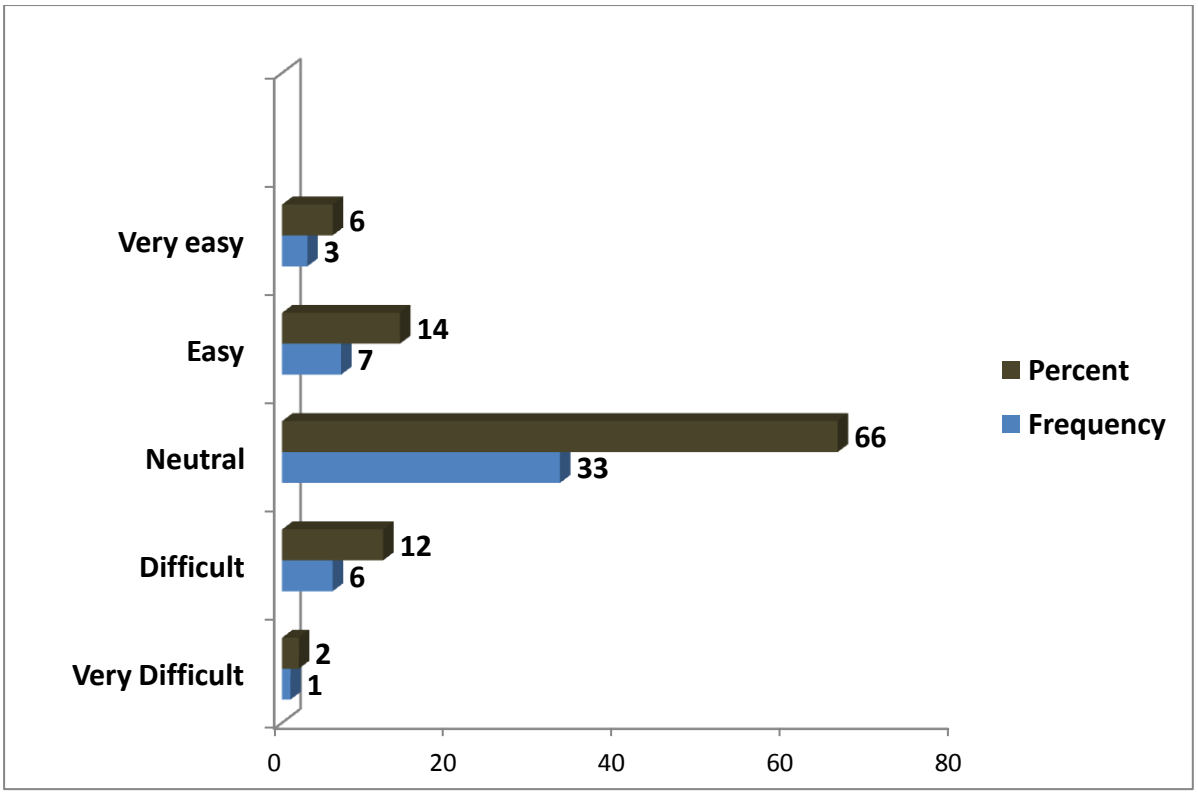


Figure 4.2: Handling of conflict between culture and LBP treatment process

4.3.2.1.2 Patient/Physiotherapy practitioner relationships

Fifty eight percent of the respondents indicated that physiotherapy practitioners were likely to have an intimate relationship with their patients. Sixty two percent of respondents indicated having had experiences where patients were attracted to them, but only 20% stated that they had been attracted to their patients. However, only 28% of respondents attributed this issue to High frequency of physical contact and treatment sessions. Table 4.6 presents these findings.

Table 4.6: Physiotherapy Practitioner and Patient Relationship

Experience	Response	Frequency	Percent	Valid Percent
Likely wood of physiotherapy practitioner to have an intimate relationship with a patient	Yes No	29 21	58.0 42.0	58.0 42.0
Physiotherapy practitioner attracted to their patient	Yes No	10 40	20.0 80.0	20.0 80.0
Patient attracted to their physiotherapy practitioner	Yes No	31 19	62.0 38.0	62.0 38.0
High frequency of physical contact with LBP patients encourage physical attraction	Yes No	14 36	28.0 72.0	28.0 72.0
High frequency of treatment sessions with LBP Patients encourage physical attraction	Yes No	14 33	28.0 66.0	29.8 70.2

Results of respondents' abilities to handle issues of physiotherapy practitioner/patient attraction are illustrated in figure 4.3**.** Respondents stated mixed opinions on how they managed to handles this issue, 34.2% had difficulties, 31.6% found it easy while another 31.6% neither found it easy nor difficult. Only 2.6% had it very easy to handle this situation.

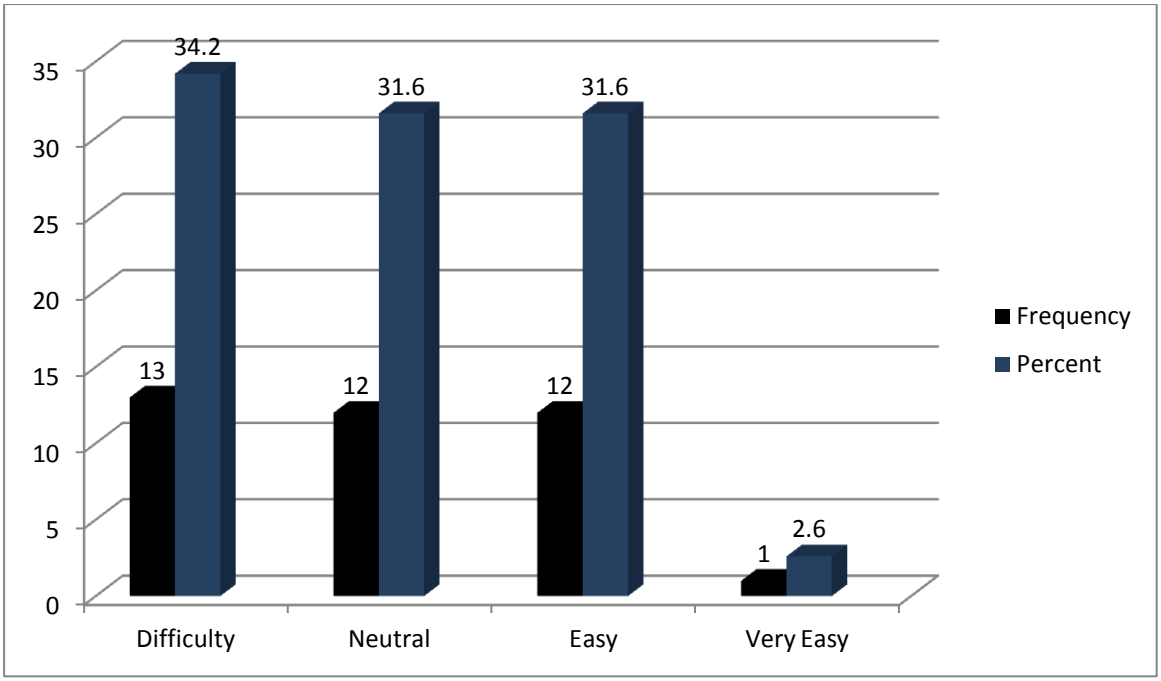


Figure 4.3: Handling of Physiotherapy Practitioner/Patient attraction.

4.3.2.1.3 Communication

Fifty eight percent of respondents indicated having encountered ethical issues on informed consent, while another 58% had conflicts with the LBP patient on ending treatment/discharge. Fifty two percent indicated having had professional conflicts on diagnosis. Table 4.7 shows these findings.

Table 4.7: Communication

Experience	Response	Frequency	Percent	Valid Percent
Informed concert Information given to patients about their condition, treatment and consent for treatment usually incomplete	Yes No	29 21	58.0 42.0	58.0 42.0
Patient conflicts on discharge Ever had conflicts with the LBP patient on ending treatment/discharge	Yes No	29 21	58.0 42.0	58.0 42.0
Professional conflicts on discharge • Ever had conflicts with the referring Doctor on ending treatment/discharge	Yes No	17 33	34.0 66.0	34.0 66.0
• Ever had a situation where the referring doctor refuses to consider your opinion opposing their diagnosis	Yes No	26 24	52.0 48.0	52.0 48.0

4.3.2.1.4 Dilemmas encountered

The fifty respondents indicated 280 responses of cases where they encountered ethical dilemmas in managing patients with LBP. On culture 50% and 46% responses indicated that respondents experienced having been Uncomfortable using hands-on techniques on patients with tattoos and traditional beads around the waist respectively**.** Discomfort due to overexposure by the patients accounted for 62% responses. On extended roles only 8% responded that they felt incompetent to give advice to LBP patients who reported problems with sexual activity. However, 56% of respondents reported being Uncomfortable to give advice on sexual activity to elderly patients.

Thirty eight percent of respondents indicated experiencing dilemmas in recognising boundaries of accepting gifts from patient. While 34% respondents reported experiencing dilemmas of having to trust patients with their own recovery due to unsupervised home programmes. Adherence to therapy was a major source of dilemmas where 58% and 64% of respondents experienced: Patients preferring prayers or traditional healers to physiotherapy; and Patients refusing a treatment program that could be beneficial preferring the treatment of their choice against your advice respectively. Fifty eight percent of respondents indicated being uncomfortable treating patients who always insisting on massage therapy only from them. Another dilemma was affecting 46% of respondents related to professional conflicts: where referring medical professions unwilling to consider physiotherapy impression on patient's diagnoses. These findings are illustrated in table 4.8.

Handling of the dilemmas encountered in management of LBP patients proved to be a challenge. Fifty percent of the respondents indicated that it was neither easy nor difficult. However, forty percent of respondents stated that handling dilemmas encountered in managing LBP was difficult. Only 10% of the respondents indicated that it was easy to handle these issues. Figure 4.4 illustrates these findings.

Table 4.8: Dilemmas Encountered in Management of LBP Patients

Dilemmas Experience	Responses		Percent of Cases
	N	Percent	
Culture:			
• Uncomfortable using hands-on techniques on patients with tattoos around waist	25	8.9%	50.0%
• Uncomfortable using hands-on techniques on patients with traditional beads around the waist	23	8.2%	46.0%
Over exposure by patients: Uncomfortable with patients who expose themselves, undress to the pants	31	11.1%	62.0%
Extended role:			
• LBP patients asked for advice on problems with sexual activity and felt incompetent	24	8.6%	8.0%
• Uncomfortable to give advice on sexual activity to elderly patients	28	10.0%	56.0%
Recognising boundaries of accepting gifts: Uncomfortable because you were offered and accepted gifts from patient	19	6.8%	38.0%
Patients active involvement in own treatment: Had to trust patients with their own recovery due to unsupervised home programmes	17	6.1%	34.0%
Adherence to therapy:			
• Patients preferring prayers or traditional healers to physiotherapy	29	10.4%	58.0%
• Patients refusing a treatment program that could be beneficial preferring the treatment of their choice against your advice	32	11.4%	64.0%
Personalisation of therapist: Uncomfortable to treat patients always insisting on massage therapy only from you	29	10.4%	58.0%
Professional conflicts: Referring medical professions unwilling to consider physiotherapy impression on patient's diagnoses	23	8.2%	46.0%
Total	**280**	**100.0%**	**560.0%**

a. Dichotomy group tabulated at value 1.

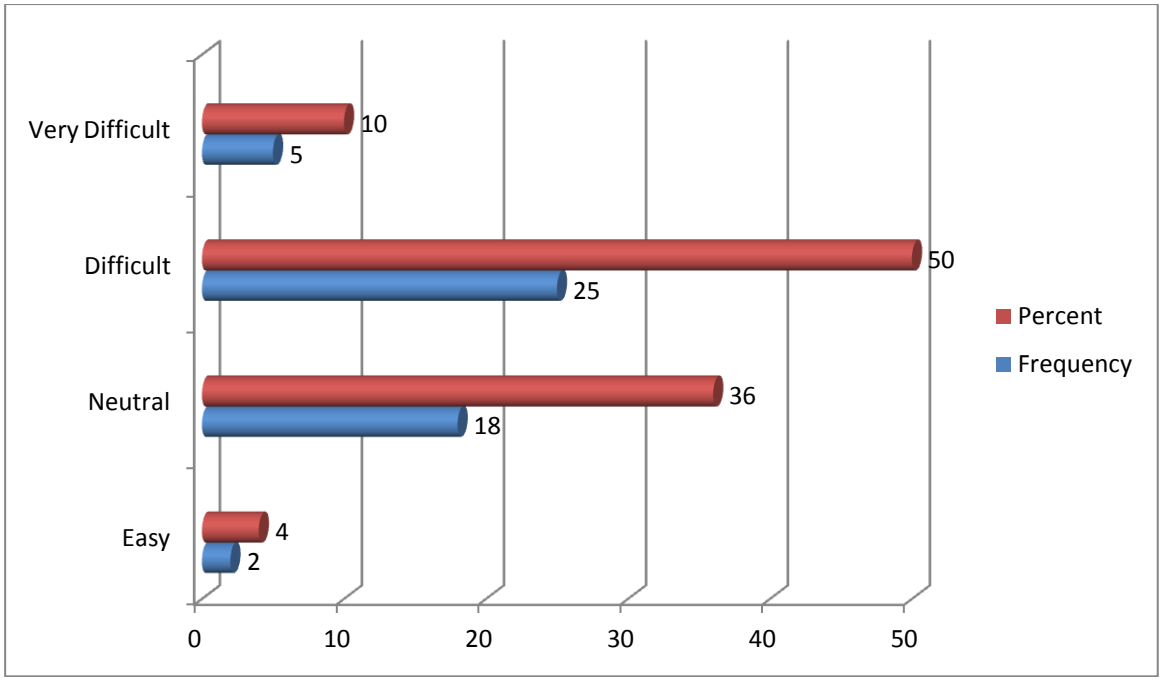


Figure 4.4: Handling the dilemmas encountered in management of LBP patients

4.3.3 Impact of ethical issues and training on physiotherapy practice

4.3.3.1 Impact of ethical issues on physiotherapy practice

Twenty six percent respondents could not agree or disagree that physiotherapy practitioners face ethical issues and dilemmas that affect their efficiency and effectiveness in managing LBP. However, 55.1% and 8.2% of the respondents agreed and strongly agreed to this statement respectively. Only 8.2% of the respondents disagreed with this statement, while 2% strongly disagreed. One participant did not give a response to this question.

4.3.3.2 Impact of training on physiotherapy practitioners' abilities to deal with ethical issues.

Ninety percent of the respondents agreed that physiotherapy training prepared practitioners to handle ethical issues encountered in management of patients with LBP. Two percent could neither agree nor disagree. Eight percent of the respondents disagreed with this statement. Table 4.9 illustrates these findings.

However, fifty percent of the respondents agreed and 12% strongly agree that Physiotherapy practitioners would benefit from further training in ethics and professional handling of ethical issues encountered in clinical practice.

Table 4.9: Impact of on physiotherapy training on handling ethical issues

	Responses	Frequency	Percent	Valid Percent
Prepared in training to handle ethical issues	Strongly Disagree	2	4.0	4.0
	Disagree	2	4.0	4.0
	Neutral	1	2.0	2.0
	Agree	24	48.0	48.0
	Strongly agree	21	42.0	42.0
	Total	**50**	**100.0**	**100.0**
Benefit from further training in ethics and professional handling	Strongly Disagree	1	2.0	2.0
	Disagree	12	24.0	24.0
	Neutral	6	12.0	12.0
	Agree	25	50.0	50.0
	Strongly agree	6	12.0	12.0
	Total	**50**	**100.0**	**100.0**

4.4 Conclusion

This study identified four dimension of ethical issues encountered in management of LBP. These included: (i) Conflict of culture and treatment process raising issues of differences of age and gender, exposure and some treatment modalities; (ii) Patient/Physiotherapy practitioner relationships; (iii) Communication; and (iv) Dilemmas encountered in management of LBP. Handling some of these ethical issues had mixed responses in both studies, with most respondents in the quantitative study not being sure on the level of difficulty they faced. The qualitative study participants disagreed on whether they were adequately prepared in training to handle ethical issues encountered in management of patients with LBP. However, 90% of the respondents in the quantitative study agreed that they were prepared in training. In both methods of study majority of practitioners in Lusaka strongly agreed that they would benefit from further training in clinical ethics particularly training in decision-making skills..

CHAPTER FIVE

DISCUSSION

5.1 Introduction

In this chapter, the results of the study are discussed in relation to the research questions, aims and objectives of the study. The discussion will focus on ethical issues encountered by physiotherapy practitioners in management of LBP. Also on whether the physiotherapy training adequately prepares physiotherapy practitioners to face ethical issues encountered in clinical practice, and whether physiotherapy practitioners require additional training in handling ethical matters faced in clinical practice. The results of the qualitative and quantitative research methods are triangulated.

5.2 Ethical issues encountered

This study revealed four dimensions of ethical issues encountered in the management of patients with LBP. These include: conflict of culture and treatment process; patient/physiotherapy practitioner relationships; communication; and several ethical dilemmas. According to Oyeyemi (2011), Magnavita (2009) and Ferrie (2006), medical and health professionals encounter ethical questions in the course of their day-to-day practices. These ethical issues/dilemmas faced by physiotherapy practitioners are not solely constituted by the decisions they have to make, but also by those that would be made by the patients. Decision-making in physiotherapy is not limited to the point of care alone; it often extends beyond treatment options. Dalany (2010) and Kirch (2010), stated that the four traditional ethical principles; respect for autonomy, beneficence, non-maleficence and justice guide the professional in evaluating situations and making decisions. These principles could be a source of conflicts and dilemmas in daily physiotherapy practice.

5.2.1 Conflict of culture and treatment process

Conflicts of culture and treatment processes in managing patients with LBP were raised. These ethical issues pertain to challenges of the patient's discomfort with exposure and hands-on techniques during treatment relating to practitioner/patient's differences in age and gender, use of massage therapy and exercises like lifting of the pelvis which patients related to sexual acts. Although most FGD participants raised these ethical issues, few of the respondents in the quantitative study had had these experiences. There was uncertainty in

handling approaches to this ethical issue with most respondents (66%) in the quantitative study stating that it was neither easy nor difficult to handle.

Physiotherapy strives for cultural competences in clinical practice but more often than not, patients cannot choose who they want as a healthcare provider (Barnett et al., 2005). All people belong to a culture, and some might even share more than one culture (UNAIDS 1999; Nkandu 2006). According to UNAIDS "Culture is a collective consciousness of a people. It is shaped by a sense of shared history, language and psychology. Cultural values are cardinal to biomedical ethics (Beauchamp & Childress 2001). Flores (2000, p.21) laments that in spite of the world having over 6000 languages, little was known about culture in health care and that clinical ramifications of culture were rarely evaluated. Further, the cultural diversity of patients was broadening daily, "…Failure to consider a patient's culture and linguistic issues can result in inaccurate histories…. decreased satisfaction with care…"

5.2.2 Patient/Physiotherapy practitioner relationships

Physiotherapy practitioners often develop close relationships with their patients such that recognition and maintenance of professional boundaries becomes a challenge. In this study it was revealed that patient/physiotherapy practitioner intimate relationships do occur. Fifty eight percent of respondents in the quantitative study affirmed to this; with 62% indicating having had experiences where patients were attracted to them and 20% stating that they themselves had been attracted to their patients. Although participants of the FGDs attributed this ethical issue to high frequency of contact with patients, misunderstanding treatment procedure by patients, and personalisation of therapists. Only 28% of respondents in the qualitative study were in agreement. In addition, handling of this ethical issue was found to be difficult and still a challenge to practitioners with only 2.6% saying that it was a very easy situation to handle.

These findings are synonymous with Poulis (2007) who echoed that physiotherapy practitioners in Australia often develop intimate relationships with their patients. In a study done earlier by Triezenberg (1996), a panel of experts identified future ethical issues relating to: the sexual and physical abuse of patients by physiotherapy practitioners or those supervised by physiotherapy practitioners; and the need for practitioners to define the limits of personal relationships within the professional setting. This was expected in the next decade or so. In a more recent study, Cooper & Jenkins (2008) revealed that Australian

physiotherapy practitioners reported having felt sexually attracted to a patient; having been sexually harassed by a patient; and having been told their touching or treatment was sexually inappropriate.

5.2.3 Communication

This study raised ethical questions in communication associated with informed consent and ending treatment/discharge. In the qualitative study an argument arose among participants on whether information given to patients was adequate for consent or not. While in the quantitative study 58% of respondents indicated that information given was inadequate. However, it was concluded that physiotherapy practitioners were more concerned about treating the patient than explaining specific diagnosis, treatment process and effects of the treatment. This was attributed to low staffing levels and work over-load. Practitioners also seemed to rely more on the assumption that the patients were well-explained to by referring doctors. The question that arises is; are the rights of the patient to autonomy being upheld? Delaney (2005) found that physiotherapy practitioners considered informed consent as a routine clinical explanation, rather than a process of providing explicit patient choices. They are concerned with information that led to a beneficial therapeutic outcome, rather than to enhance autonomous patient choice.

The other issue relating to communication, was on who should make the final decision on discharging a patient. The referring doctor refers the patient for physiotherapy with a specific goal, the patients may also have their own expectations and the physiotherapy practitioners also set their own goals. Most practitioners felt that they had to make the final decision to end treatment regardless of opinions of other professionals or patient**,** insisting that they set their own goals of treatment. This raised conflicts with most patients as revealed by 58% of respondents in the quantitative study; where patients have refused to be discharged, although few (34%) experienced situations where doctors referred discharged patients back to physiotherapy. This ethical issue is also described by Purtilo et al., (2005) as a "locus of authority" problem.

The Zambian Standards of Physiotherapy Practice (2012), states that communication is an integral element of every patient and professional encounter and facilitates the provision of cost effective and appropriate physiotherapy services.

5.2.4 Dilemmas encountered

According to Grace & Hardt (2008), health care professionals are responsible for fulfilling the goals of health care services-to promote well-being, cure illness, and ease suffering. Certain ethical principles can guide their efforts. But which principle should take precedence can be a huge dilemma**.** In this study the ethical dilemmas encountered by physiotherapy practitioners were related to culture; over exposure by patients; extended role of practitioners; recognising boundaries of accepting gifts; patients active involvement in their own treatment; adherence to therapy; personalisation of therapist; personalisation of therapist. The fifty respondents in the quantitative study gave 280 responses of cases relating to ethical dilemmas encountered in managing patients with LBP.

Culture in relation to traditional norms and social aspects raised issues of physiotherapy practitioners'/patients' comfort with treatment process and consequently affecting the effectiveness of treatment. Traditional norms of wearing beads and/or having tattoos around the waist seen in LBP patients' causes discomfort for practitioners especially where patients came with fresh tattoos. Fifty percent of respondents raised concerns of patients wearing beads and 46% raised those of tattoos around waist. This study also showed that practitioners (62%) found it very difficult to treat patients who tend to **overexpose** themselves despite being asked to only expose the lower back. The other source of discomfort for practitioners was the **personalization of physiotherapy practitioner, with** 58% of practitioners indicating having experienced this dilemma. Some patients insisted on being seen by a particular practitioner so much that their intensions were questionable. In a study on ethical dilemmas of peer physical examination in pelvic floor physiotherapy practice among Australian students, Delany & Frawley (2012), raised the issue of how students could feel pressurised to participate despite their own discomfort and embarrassment. The question that arises is, should practitioners be obliged to treat patients despite their own discomfort?

It was observed that the nature of this condition, that is LBP, brings about associated problems of sexual function in patients. To solve this problem they had often **extended roles** by involving themselves in their patient's personal lives through advice and counselling. This is supported by Kamau (2005) who reported that patient with LBP face problems with sexual function. Furthermore, female patients would appreciate if their husbands were counselled on sex in relation to their LBP. Although most of the practitioners felt quite competent to give this advice most expressed discomfort in giving advice and counselling elderly patients but

felt compelled to do so because of their profession. Fifty six percent of practitioners in the quantitative study were also in agreement. Haboubi & Lincoln (2003) concluded that health professionals agreed that patients' sexual issues needed to be addressed and discussed in health services. However, they were poorly trained, ill prepared and rarely participated in such discussions. This suggests that training in sexuality and sexual issues should be implemented as part of the training of physiotherapy practitioners.

The other dilemma was **recognising boundaries of accepting gifts** from patients. Physiotherapy practitioners face conflict of professional ethics and social/cultural norms, where gifts are offered to them by patients as a way of appreciation. The physiotherapy ethical code of practice does not allow accepting gifts or other considerations that influence or give an appearance of influencing their professional judgment from patients (WCPT 2011, Swisher & Hiller 2009 and CSP 2008). Having come from the same social/cultural background as the patients, physiotherapy practitioners are faced with a dilemma and are most of the time compelled to accept the gifts or see them as a sign of appreciation. This was also echoed in the quantitative study where only 38% of respondents mentioned that they were uncomfortable to accept gifts from patient. However, these practitioners who reported having faced this dilemma were forced to discharge or refer patients to another practitioner, or even go on leave so as to avoid the patient. Consequently disturbing the patients treatment programme.

The **patient's active involvement in their own treatment** also raises concerns of unsupervised home programmes and lack of professional follow up through community based rehabilitation programmes. However, this concern was only raised by 34% of the respondents in the quantitative research. Physiotherapy practitioners have to trust in feedback from caregivers or trust that patients are doing the correct things at home. McLean et al., (2010) noted that patients are given exercise programmes to follow at home with no professional supervision. The questions that arise are: Can the physiotherapy practitioner be sure that the patient is doing the correct pattern of exercise? Who is responsible for effective rehabilitation, the patient, the caregiver or the professional?

The issue of **adherence to therapy** was another challenge to practitioners in that they had little choice but to respect patient's rights. It was noted that patients may or may not adhere to therapy. Practitioners cannot stop patients who want to concentrate on prayers or traditional healers instead of physiotherapy. Sixty four percent of respondents in the quantitative study

stated having encountered this dilemma. A systematic review by Jack, McLean, Moffett & Gardiner (2010) reported strong evidence that poor treatment adherence was associated with low levels of physical activity at baseline or in previous weeks, low in-treatment adherence with exercise, low self-efficacy, depression, anxiety, helplessness, poor social support/activity, greater perceived number of barriers to exercise and increased pain levels during exercise. However, Marwaha, Horobin & McLean (2010) also identified factor to adherence which appear to be common to all nations but unique to third world countries like India were issues of social and cultural factors were raised. Physiotherapy practitioners in this study had also related to the cultural factors posing a challenge to adherence. Another dilemma was the issue of **professional conflicts**. Participants revealed that some referring medical professions hesitate to consider physiotherapy practitioner's impression on patient's diagnosis hence delaying treatment. The physiotherapy practitioner watches the patient's condition deteriorate and has the challenge of convincing the doctor to re-examine patient. Forty six percent of participants indicated having had this experience.

Handling of these dilemmas proved to be a challenge with only 10% of the respondents' indicating that it was easy. A patient's right to make her or his own choices exists even when experts disagree with the choices the person is making. Conflict can arise because physiotherapy practitioners also have a responsibility to avoid causing harm, as expressed by the ethical principle of nonmaleficence. Physiotherapy practitioners are also obliged to give treatment that is beneficial to the patient (beneficiency) and to uphold the principle of justice in their delivery of healthcare.

5.3 Impact of training on physiotherapy practitioners' abilities to deal with ethical issues.

Training in ethics is cardinal for any healthcare profession. Physiotherapy training programmes must be equipped to produce quality graduates with ethical decision-making capabilities. According to Greenfield & Jensen (2010), Physiotherapy practitioners have a central role in rehabilitation and working with people with disabilities and as such, need skills that will help them develop a rich understanding of the physical, cognitive, emotional, and moral changes and challenges that arise with individuals who have disabilities.

The physiotherapy curriculum at UNZA (2007) and EHC (2005), the two physiotherapy training institutions at the time of this study, indicates some topics taught on physiotherapy

ethics. None of the participants of the qualitative study indicated have had additional training on ethics while only 29.8% of participants in the quantitative study had had such training. The question that arises is that was the training adequate? The qualitative component of this study revealed that participants could not agree on whether their training in clinical ethics adequately prepared them to handle all the ethical issues that they faced in their practice. Looking at the great challenges they faced as practitioners in the field pertaining in handling ethical issues, it was difficult to state that they were adequately prepared in training. On the other hand, 90% of the respondents in the quantitative study agreed that physiotherapy training prepared practitioners to handle ethical issues encountered in managing patients with LBP.

Ironically, participants stated different methods of approaching similar ethical issues. Others even stated they did not know what to do. Further stating that usually when ethical issues arouse, practitioners would either use their initiative to deal with the issue; consult senior practitioners on the issue; and/or have learnt how to deal with ethical issues through experience and other health workers like social workers. Participants also said that they felt compelled to respect cultural norms. In the quantitative study most respondents, 66% and 50% were not sure on whether they found it difficult or easy to handle ethical issues relating to culture conflicts with treatment process and dilemmas encountered respectively. On the issue of physiotherapy practitioner/patient relationships, 31% of respondents were also not sure on how they found handling this issue while another 34% actually found it difficult to handle.

However, participants strongly agreed that they would all benefit from further training on ethics in clinical practice. This was supported by 62% of respondents from the quantitative study who agreed that Physiotherapy practitioners would benefit from further training in ethics, decision-making and professional handling of ethical issues encountered in clinical practice.

The study revealed that practitioners felt they needed workshops or seminars to tackle topics on decision-making in tackling ethical issues; cultural beliefs in relation to management of LBP; and counselling skills. This is supported by Oyeyemi (2011), who stated that Physiotherapists must be accountable for making sound professional decisions and must be equipped through training and self-development activities. Kirch (2010), added that there has

been an increase in awareness on ethics in the physiotherapy profession but not much address has been given to ethical decision making skills of physiotherapy practitioners.

5.4 Conclusion

This study revealed several ethical issues faced by physiotherapy practitioners in managing patients with LBP. It is evident that most practitioners have difficulties handling these ethical issues in their day to day practice despite stating that they were adequately prepared in training to handle them. However the majority of the physiotherapy practitioners do strongly agree that further training on ethics in clinical practice would be beneficial.

CHAPTER SIX

SUMMARY, CONCLUSION, RECOMMENDATION, LIMITATION

6.1 Summary

The purpose of this study was to explore and provide additional insight into the nature and scope of ethical issues and dilemmas encountered by physiotherapy practitioners in Lusaka, managing patients with LBP. The study determined whether physiotherapy practitioners are adequately prepared in training to handle ethical issues encountered in clinical practice. The study utilized the method of triangulation by combining both qualitative and quantitative research methods in order to complement each other and to provide adequate understanding of the study outcome. Two FGDs with eight participants in each group were conducted, one at UTH and the other at LMGH. The second component of the study namely quantitative research involved a structured questionnaire. The questionnaire was distributed among the rest of the physiotherapy practitioners in Lusaka and had fifty respondents.

The themes that were deduced from the FGDs were; conflict of culture and treatment process; patient/physiotherapy practitioner relationships; communication; ethical dilemmas; and impact of training on physiotherapy practitioners' abilities to deal with ethical issues. Respondents in the quantitative study mostly related to having ethical issues in the dimensions of; patient/physiotherapy practitioner relationships; informed consent in communication; and ethical dilemmas relating to practitioners discomfort with (i) culture – patients with tattoos around the waist. (ii) Patients who overexpose themselves (iii) Extended role – advising elderly patients on sexual issues. The other dilemmas that were mostly encountered were that of patient's adherence to therapy and personalisation of therapist.

The results further showed that participants could not agree on whether their training in clinical ethics adequately prepared them to handle all the ethical issues that they faced in their practice. Some felt that they were well trained on how best to handle certain issues. While other participants argued that looking at the great challenges they faced as practitioners in the field pertaining to handling ethical issues, they could not say that they were adequately prepared in training. On the other hand, 90% of the respondents in the quantitative study agreed that physiotherapy training prepared practitioners to handle ethical issues encountered in management of patients with LBP. Only 8% of the respondents disagreed with this statement and the remaining 2% were not sure. Ironically, participants indicated challenge in

handling these ethical issues and strongly agreed that they would benefit from further training on ethics in clinical practice.

6.2 Conclusions

The study outcome shows that physiotherapy practitioners encounter ethical issues in the management of patients with LBP. Although practitioners' state that their training adequately prepared them to tackle ethical issue in clinical practice, the study shows that a majority had difficulties in handling the ethical issues raised. The study also revealed that physiotherapy practitioners strongly agreed that they would benefit from further training on ethics in clinical practice.

6.3 Recommendations

The following recommendations are made on the basis of the findings of the study.

6.3.1 Recommendations to physiotherapy training institutions

Although physiotherapy practitioners in Lusaka indicated that their training prepared them to effectively handle ethical issues encountered in clinical practice. They also indicated challenges when handling these issues. It would be beneficial to train more on decision making skills.

6.3.2 Recommendation to the Physiotherapy Profession in Zambia

The use of Standards of Practice has been found to provide excellence and consistency of service delivery (Chartered Society of Physiotherapy 2000 Revision). The resent formulation of Standards of Practice for physiotherapy practitioners in Zambia is a positive move. However, the researcher recommends that the ZSP, through the MOH Chief Physiotherapist initiate sensitisation workshops and seminars for physiotherapy practitioners on good Standards of Practice.

6.3.3 Further research

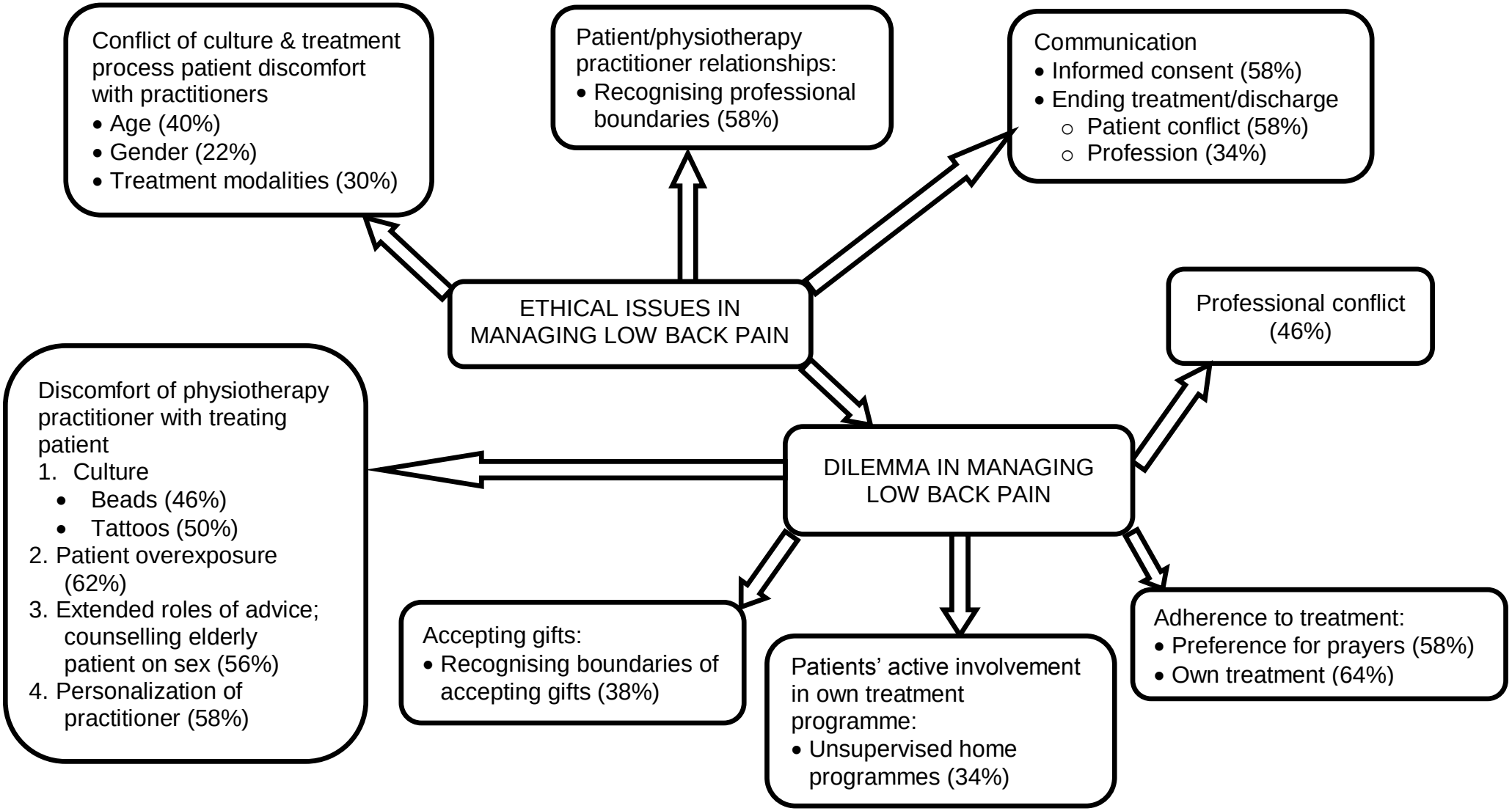
It is recommended that similar studies to be carried out in other hospitals and health institutions that offer physiotherapy in Zambia to explore ethical issues encountered by physiotherapy practitioners in managing patients with LBP. This will improve generalisability of the results. This study also provides a database for further research in the specific dimensions of ethical issues identified.

The study also brought out the implications of ethical issues to physiotherapy practise. Further research in this topic is also highly recommended in order to determine the effect on the Standards on Practice.

6.4 Limitations of the Study

Initially the focus groups were expected to constitute physiotherapy practitioners from UTH and Zambia Italian Orthopaedic Hospital (ZIOH) in Group A, and physiotherapy practitioners from LMGH and Chainama Hills College Hospital (CHCH) for Group B. However practitioners from ZIOH and CHCH did not participate in the FGDs due to communication breakdown and non availability of practitioners at that time, respectively. This meant that ethical issues identified were based on experiences of practitioners in two hospitals only. However, some participants had worked in rural and private hospitals, so were able to share their experiences on ethical issues encountered in these settings.

FIGURE 6.5: SUMMARY OF ETHICAL ISSUES ENCOUNTERED IN MANAGING LBP.



REFERENCES

Al-Eisa E (2010). Adherence to physiotherapy attendance among Saudi female patients with mechanical low back pain: A clinical audit. BMC Musculoskeletal Disorders, 11:124. http://www.biomedcentral.com/1471-2474/11/124

APTA (2004). *Normative Model of Physical Therapist Professional Education: Version 2004. APTA: Washington, USA.*

Baker J & Stiller K (2006). Chronic illness: a view from the other side. *Aust J Physiother*; 52:155–156.

Barnett J, Behnke S, Rosenthal S & Koocher G (2005). In case of ethical dilemma, break glass: Commentary on ethical decision making in practice. *Professional Psychology: Research and Practice 38(1):7–12.*

Barnitt R (1998). Ethical dilemmas in occupational therapy and physical therapy: a survey of practitioners in the UK National Health Service. *Journal of Medical Ethics; 24:193*

Beauchamp T & Childress J (2001). Principles of Biomedical Ethics 5th Edition Oxford University Press.

Braunack-Mayer AJ (2001). What makes a problem an ethical problem? An empirical perspective on the nature of ethical problems in general practice. *Med Ethics; 27:98-103 doi:10.1136/jme.27.2.98*

Burns, RB (2000). Introduction to research methods, fourth edition. London: Sage.

Cameron R (2011*).* **"**Mixed methods in business and management**:** A call to the 'first generation", *Journal of Management and Organisation. Vol.17, No. 2. March, pp 245-267*

Cameron & Michelle H (2003). Physical agents in rehabilitation: from research to practice. Philadelphia: W. B. Saunders. ISBN 6-9378-4.

Canadian Physiotherapy Association-CPA (2003): Code of Ethics.

Carpenter C & Richardson B *(*2008). Ethics knowledge in physical therapy: a narrative review of the literature since 2000 . *Phys Ther*; 13:366–374**.**

Central Statistical Office (2010). Census of population and housing; Presentation on selected indicators.

Chartered Society of Physiotherapy - CSP (2008). Core standards of physiotherapy practice. London, UK.

Chartered Society of Physiotherapy- CSP (2002). Rules of Professional Conduct. www.csp.org.uk Page 15/41 Ref:

Chartered Society of Physiotherapy- CSP (2005). Core Standards of Physiotherapy Practice. Pub Chartered Society of Physiotherapy, London, UK.

Cooper I & Jenkins S (2008). Sexual boundaries between physiotherapists and patients are not perceived clearly: an observational study. *Australian Journal of Physiotherapy 54: 275–279]*

Curriculum - Bachelor of Science Degree in Physiotherapy (2007). University of Zambia, School of Medicine,

Curriculum – Diploma in Physiotherapy (2005). Evelyn Hone College of Applied Arts and Sciences, Physiotherapy Section.

Delany C & Frawley H (2012). A process of informed consent for student learning through peer physical examination in pelvic floor physiotherapy practice. *Physiotherapy; 98(1): 33-39*

Delany CM, Edwards I, Jensen GM. & Skinner E (2010). Closing the Gap between Ethics Knowledge and Practice Through Active Engagement: An Applied Model of Physical Therapy Ethics. *Physical Therapy Volume 90; Number 7.*

Delaney CM (2005). Respecting patient autonomy and obtaining their informed consent: Ethical theory- missing in action. Physiotherapy 91; 197-205

De Vos AS (2001). Research at grass root: A primer for the caring professionals. Pretoria: Van Schaik.

ER-WCPT (2010). Glossary of terms: Adopted at General Meeting of the Europe Region of the WCPT.

Ferrie S (2006). A quick guide to ethical theory in healthcare: solving ethical dilemmas in nutrition support situations. *Nutr Clin Pract*; 21(2): 113-

Flores G (2000). Culture and the patient-physician relationship: Achieving Cultural Competency in Health Care, Journal of Paediatrics, 136:14-23

Flett PJ & Stoffell BF *(*2003). Ethical issues in paediatric rehabilitation. *J Paediatr Child Health*; 39:219–223.

Fritz MJ, Cleland AJ & Childs (2007). Sub - grouping patients with low back pain, Evaluation of a classification approach to physical therapy, a clinical commentary. *Journal of Orthopaedics and Sports Physical Therapy, Vol 37:12.*

Gabard DL & Martin MW (2003). Physical Therapy Ethics, Philadelphia: F. A. Davis.

Gibson BE, Darrah J, Cameron D, et al *(*2009). Revisiting therapy assumptions in children's rehabilitation: clinical and research implications. *Disabil Rehabil*; 31:1446–1453.

Golofshani N (2003). Understanding Reliability and Validity in Qualitative Research; The Qualitative Report. Vol 8; Number 4. http//www.nova.edu/ssss/QR/QR8-4/ golofshani.pdf

Grace PJ and Hardt EJ (2008). Ethical Issues: When a Patient Refuses Assistance *American Journal of Nursing Vol 108; 8 ;36 – 38.*

Greenfield BH and Jensen GM (2010). Understanding the Lived Experiences of Patients: Application of a Phenomenological Approach to Ethics. *PHYS THER.* 90:1185-1197.

Haboubi NHJ and Lincoln N (2003). Views of health professionals on discussing sexual issues with patients. Vol. 25, No. 6 , Pages 291-296

Health Professions Council of Zambia (2012): Data base.

Higgs J, Smith M, Webb G & Skinner M (2008). eds, Contexts of Physiotherapy Practice. Sydney, Australia: Elsevier.

Hycner RD (1985). Some Guidelines for the Phenomenological Analysis of interview Data. *Martinus Ni/hoff Publishers, Dordrecht. Netherlands. Human Studies 8:279-303.*

Iyalomhe GB (2009). Medical Ethics and Ethical dilemmas. *Niger J Med*; 18(1): 8-16.

Jack K, McLean S, Moffett J & Gardiner E (2010). Barriers to treatment adherence in physiotherapy outpatient clinics: A systematic review.

Kamau PW (2005). Patient satisfaction with physiotherapy services for low back pain at selected hospitals in Kenya. Thesis: Department of Physiotherapy, University of the Western Cape.

Kelly AV (2009). The Curriculum Theory and Practice, 6th Edition, Sage Publications Ltd. London, UK.

Kirsch N (2009). Ethical decision making: Application of a problem-solving model. *Topics in Geriatric Rehabilitation* 25(4):282–91.

Kirsch NR (2010). California: Ethical Decisions in Physical Therapy, *www.atrainceu.com/pdf/46_CA_PT_Ethics.pdf*

Klaus K (2004). *Content Analysis: An Introduction to Its Methodology. 2nd edition, Thousand Oaks, CA: Sage*

Krueger RA (2006). "The Focus Group Kit" Sage Publications Inc., 2455 Teller Rd. Thousand Oaks, CA 91320

Latimer J, Maher C, & Refshauge K *(*2004). The attitudes and beliefs of physiotherapy students to chronic back pain. *Clinical J Pain*; 20:45–50.

Magnavita NBA (2009). Ethical problems in radiology: radiological consumerism. *Radiol Med*; 114(7):1173-1181.

Malterud K (2001). Qualitative research: standards, challenges, and guideline. The Lancet, 358:483-88

Marwaha K, Horobin H, McLean S. (2010). Indian physiotherapists' perceptions of factors that influence the adherence of Indian patients to physiotherapy treatment recommendations.. *International Journal of Physiotherapy and Rehabilitation. Sep 15 [last modified: 2013 Apr 15]. Edition 1.*

Mclean S, Burton M, Bradley I & Littlewood C (2010). Interventions for enhancing adherence with physiotherapy: a systematic review. Manual therapy, 15 (6), 514-521

Morse JM, Barret M, Mayan M, Olson K, & Spiers J (2002). Verification Strategies for Establishing Reliability and Validity in Qualitative Research, *International Journal of Qualitative Methods 1 (2) Spring.*

Nkandu EM (2004). To What Did They consent? A Review of the Consent Process as seen in a Study Conducted in Mazabuka Zambia -University of Cape Town, South Africa. Mini thesis towards Post Graduate Diploma in International Research Ethics

Nkandu EM (2006). The Development of a Training Programme for Peer Learning Educators in Adolescent Reproductive Health in Zambia. University of Stellenbosch Cape Town, South Africa. PhD Thesis

Oyeyemi A (2011). Ethics and Contextual Framework for Professional Behaviour and Code of Practice for Physiotherapists in Nigeria. *Journal of the Nigeria Society of Physiotherapy – Vols. 18 & 19*

Pensri P, Foster NE, Baxter GD & McDonough SM (2005). Physiotherapy management of low back pain in Thailand: a study of practice. *Physiotherapy Research International 10(4) 201–212. DOI: 10.1002/pri.16.* John Wiley & Sons, Ltd

Poulis I (2007). Bioethics and physiotherapy. *Journal of Medical Ethics, 33:435-436.*

Poulis I (2007). The end of physiotherapy. *The Australian Journal of Physiotherapy, 53:71-2.*

Praestegaard J & Gard G (2011). The perceptions of Danish physiotherapists on the ethical issues related to the physiotherapist patient relationship during the first session: a phenomenological approach. BMC Medical Ethics, 12:21 http://www.biomedcentral.com/1472-6939/12/21

Purtilo RB, Jensen GM & Royeen CB (2005). *Educating for Moral Action: A Source book in Health and Rehabilitation Ethics*. Philadelphia, PA: FA Davis Co; p 41

Sackett D (1996). Evidence Based Medicine – What it is and what it isn't**.** BMJ: 312:71-72 available at http://www.Bmj.com/cgi/contents/full/312/7028/71.

Shenton AK (2003). Strategies for ensuring trustworthiness in qualitative research projects.

Southorn N (2010). Musculoskeletal assessment, The Student's Companion to Physiotherapy

Standards of Physiotherapy Practice (2012). Ministry of Health, Republic of Zambia.

Swisher LL & Hiller P (2009). The Revised APTA *Code of Ethics* for the Physical Therapist and *Standards of Ethical Conduct for the Physical Therapist Assistant*: Theory, Purpose, Process, and Significance.

Swisher LL (2002). A retrospective Analysis of Ethics Knowledge in Physical Therapy (1970-2000). *Physical Therapy, 82(7):692-706.*

Tashakkori A & Teddlie C (2010). Sage Handbook of Mixed Methods in Social & Behavioral Research. Thousand Oaks, CA, Sage Publications

Tinana T (2004). Guidelines for Cultural Competence in Physiotherapy Education and Practice in Aotearoe / New Zealand. New Zealand Society of Physiotherapists, Annual General Meeting,

Triezenberg HI (1996). The Identification of Ethical Issues in Physical Therapy Practice. *Physical Therapy. 76. 10*

UNAIDS (1999). *Communications Framework for HIV/AIDS. A New Direction.* UNAIDS/Penn State Project, Geneva.

University Teaching Hospital (2012). Department of Physiotherapy Records.

Vagias & Wade M (2006). *Likert-type scale response anchors*. Clemson International Institute for Tourism & Research Development, Department of Parks, Recreation and Tourism Management. Clemson University.

Valente SM & Saunders JM (2000). Oncology nurses' difficulties with suicide. *Med Law* 19(4): 793–814.

Veatch RM (2003). *The Basics of Bioethics.* Upper Saddle River, NJ: Prentice-Hall.

Woolf AD & Pfleger B (2010). Burden of major musculoskeletal conditions. *Bull World Health Organ.* Sep: 81(9)

World Confederation for Physical Therapy (2011). Ethical Principles. London, UK: WCPT;

www.wcpt.org/ethical-principles

World Confederation for Physical Therapy (2007). Declarations of principle and position statements. http://www.wcpt.org/common/docs/ WCPTPolicies.pdf

World Confederation for Physical Therapy (2011). Policy statement and Description of physical therapy.

Yount R (2006). Research and Statistical analysis for Christian Ministry. Population and Sampling. 4th Edition.

Zambia Society for Physiotherapy (2011). Annual General Meeting and Scientific Symposium, Secretary Generals' Report.

APPENDICES

APPENDIX I: INFORMATION SHEET FOR FOCUS GROUP

Dear participant

I am a student at the University Of Zambia School Of Medicine pursuing a Master of Science Degree in Physiotherapy–Orthopeadics. I am undertaking an exploratory research on ethical issues encountered by physiotherapy practitioners in Lusaka, managing patients with Low Back Pain. This study will contribute to improving on the body of knowledge.

- ✓ The aim of the study is to explore and provide additional insight into the nature and scope of ethical issues and dilemmas encountered by physiotherapy practitioners in Lusaka, managing patients with Low Back Pain. The study will also determine whether physiotherapy practitioners are adequately prepared in training to handle ethical issues encountered in clinical practice

This study will expose if there are any ethical issues encountered by physiotherapy practitioners in the management of LBP, factors which influence these issues and will also determine the preparation of physiotherapy practitioners in managing ethical issues. The study will inform physiotherapy trainer and stimulate further research.

Your participation in this study is voluntary and the information that will be given shall be handled with strict confidence. You are not required to write your name or initials on the questionnaire to avoid identity. Be informed that not participating in this study will not affect your right to practice at any time.

Please note that the study is purely academic and there are no monitory benefits.

You are being requested to take part in a tape recorded Focus Group Discussion for 1 hour.

If you have any questions contact me or the secretary of the Research Ethics Committee

Your support will be greatly appreciated.

ERES CONVERGE IRB
33 Joseph Mwilwa Road
Rhodes Park
Lusaka

Phone: 0955 155 633/4

Kangwa M Chileshe
University of Zambia
Physiotherapy Department
Box 50110
Lusaka
Kmchileshe@yahoo.com

Mobile 260-96-6588728

APPENDIX II: INFORMATION SHEET FOR QUESTIONNAIRE

Dear participant

I am a student at the University Of Zambia School of Medicine pursuing a Master of Science Degree in Physiotherapy–Orthopeadics. I am undertaking an exploratory research on ethical issues encountered by physiotherapy practitioners in Lusaka, managing patients with Low Back Pain. This study will contribute to improving on the body of knowledge.

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This study will expose if there are any ethical issues encountered by physiotherapy practitioners in the management of LBP, factors which influence these issues and will also determine the preparation of physiotherapy practitioners in managing ethical issues. The study will inform physiotherapy trainer and stimulate further research.

Your participation in this study is voluntary and the information that will be given shall be handled with strict confidence. You are not required to state your name during the discussion to avoid identity. Be informed that not participating in this study will not affect your right to practice.

Please note that the study is academic and there are no monitory benefits.

You are being requested to answer a questionnaire, which will take 15 minutes.

If you have any questions contact me or the secretary of the Research Ethics Committee

Your support will be greatly appreciated.

ERES CONVERGE IRB
33 Joseph Mwilwa Road
Rhodes Park
Lusaka
Phone: 0955 155 633/4

Kangwa M Chileshe
University of Zambia
Physiotherapy Department
Box 50110
Lusaka
Kmchileshe@yahoo.com

Mobile 260-96-6588728

APPENDIX III: INFORMED CONSENT

I ……., have read and understood the aims of this study. I am aware of my rights in not taking part in the study and that it will not affect my physiotherapy practice at any given time. I am also aware that I can withdrawal from the study at any point without giving any notice.

I have therefore agreed to take part in the study with my own free will.

Participant's signature…… Date……

Researcher's signature…… Date……

APPENDIX IV: FOCUS GROUP QUESTIONS GUIDE

Theme 1: Culture conflicts

1. What has been your experience in treating LBP patients where there is differences in your age / gender?
2. How do you feel about examining or treating LBP patients with traditional beads in the waist?
3. In your experience have LBP patients asked for advice on sexual function?

Theme 2; Physiotherapy Practitioner/Patient Relationships

1. In your experience have you ever had a patient of the opposite sex deliberately over-expose themselves on a consequent session despite your clear instruction?
2. What do you think about patient/practitioner intinate relationships? Have you ever experienced this situation?
3. How have you handled situation where LBP patients offer gifts which are suggestive?

Theme 3: Patients' Involvement

1. How do you determine whether the patient is following instructions and advice on home programmes?
2. What do you think about the responsibilities which patients have towards their own treatment?
3. What information do you generally give to your patient to obtain informed consent?
4. What have you done in a situation where the patient refuses treatment that could be beneficial in preference for a treatment of their choice against your advice?

Theme 4: Physiotherapy skill

1. How do you select the treatment modalities?

2. In your experience who has the final decision to discharge patients with Low Back Pain?
3. How have you handled situations where the doctor opposes your decision to discharge a patient or continue treating the patient?
4. How have you handled situations where the patient opposes your decision to continue or discontinue treatment?

Theme 5: Adequate training in clinical ethics

1. What do you think about your training in preparing you to handle ethical issues encountered in management of patients with LBP?
2. Do you think you would benefit from further training in ethics and ethical decision making?

APPENDIX V: QUESTIONNIARE

Date …../ …../ ….. Serial No ……..

THE UNIVERSITY OF ZAMBIA

DEPARTMENT OF PHYSIOTHERAPY

The aim of the study is to explore and provide additional insight into the nature and scope of ethical issues and dilemmas encountered by physiotherapy practitioners in Lusaka, managing patients with Low Back Pain. The study will also determine whether physiotherapy practitioners are adequately prepared in training to handle ethical issues encountered in clinical practice

INSTRUCTIONS

Read questions carefully before you answer/

Tick the correct responses in the space provided.

SECTION A: DEMOGRAPHIC DATA

1 Age – years

a) 16 – 24 ☐
b) 25 – 35 ☐
c) 36 – 45 ☐
d) 46 – 55 ☐
e) Over 55 ☐

2 Gender

Male ☐ Female ☐

3 Marital status

a) Single ☐
b) Married ☐
c) Divorced ☐
d) Widowed ☐

4 State your nationality. ……..

5 Work experience

a) 1 - 5 years ☐
b) 6 - 10 years ☐
c) 11 - 15 years ☐
d) 16 - 20 years ☐
e) Over 21 years ☐

6 What is your religion?

a) Christian ☐
b) Moslem ☐
c) Hindu ☐
d) If others please state. ……

7 What is your highest qualification?

a) Diploma ☐
b) Degree ☐
c) Masters ☐
d) Others, please specify …….

8 Where did you attain your highest physiotherapy qualification?

a) Evelyn Hone College ☐
b) University of Zambia ☐
c) If others please state …….

9 Have you ever received any additional training in clinical ethics?

Yes ☐ No ☐

SECTION B: ETHICAL ISSUES

Conflicts of Culture and treatment process

10 Are you uncomfortable when treating LBP patients who are of the opposite sex?

Yes ☐ No ☐

11 Are you uncomfortable when treating LBP patients who are older than you?

Yes ☐ No ☐

12 In your experience, has a LBP patient ever asked to be treated by another physiotherapy practitioner on the basis of your age?

Yes ☐ No ☐

13 In your experience, has a LBP patient ever asked to be treated by another physiotherapy practitioner on the basis of your gender?

Yes ☐ No ☐

14 In your experience/observation, do LBP patient have difficulties to expose the back during examination or treatment?

Yes ☐ No ☐

15 In your experience, have you observed some treatments e.g. massage therapy, electrical stimulation causing sexual arousal in some LBP patients?

Yes ☐ No ☐

16 In your opinion/observation, do some LBP patients hesitate to do Bridging because they relate it to a sexual act?

Yes ☐ No ☐

17 How have you generally found handling these situations of conflicts between culture and LBP treatment process?

a) Difficult ☐
b) Very difficult ☐
c) Easy ☐
d) Very easy ☐

Physiotherapy Practitioner/Patient Relationships

18 In your opinion, is it likely for a physiotherapy practitioner to have an intimate relationship with a patient?

Yes ☐ No ☐

19 Have you ever been physically attracted to your patient?

Yes ☐ No ☐

20 Has a patient ever been physically attracted to you?

Yes ☐ No ☐

21 If your answer in question 19 and/or 20 is 'yes', state how you found handling these situation?

a) Difficult ☐
b) Very difficult ☐
c) Easy ☐
d) Very easy ☐

22 In your opinion, does the high frequency of physical contact with patients in management of LBP, encourage physical attraction between patients and physiotherapy practitioners?

Yes ☐ No ☐

23 In your opinion, does the high frequency of treatment sessions in management of LBP, encourage physical attraction between patients and physiotherapy practitioners?

Yes ☐ No ☐

Communication

24 In your opinion, is the information given to patients about their condition and treatment process, to obtain informed consent for treatment, usually incomplete?

Yes ☐ No ☐

25 In your experience of managing LBP, have you ever had conflicts with the patient on ending treatment/discharge?

Yes ☐ No ☐

26 In your experience of managing LBP, have you ever had conflicts with the referring doctor on ending treatment/discharge?

Yes ☐ No ☐

27 In your experience of managing patients with LBP, have you ever had a situation where the referring doctor refuses to consider your opinion opposing their diagnosis?

Yes ☐ No ☐

Dilemmas encountered in management of LBP

Tick the situations you have encountered

28 In your experience of managing patients with LBP, have you ever encountered any of the following dilemmas?

a	Uncomfortable using hands-on techniques on patients with traditional tattoos around the waist.	
b	Uncomfortable using hands-on techniques on patients with traditional beads around the waist.	
c	Uncomfortable with patients who over expose themselves, undress to the pants despite receiving instructions to only expose the back.	
d	LBP patients asked for advice on problems with sexual activity, which you felt incompetent or difficult to handle.	
e	Uncomfortable to give advice on sexual activity to elderly patients.	
f	You were offered and accepted gifts from your patients, which made you uncomfortable.	
g	Have to trust patients with their own recovery due to unsupervised home programmes and lack of professional follow up.	
h	You have encountered patients prefer to concentrate on prayers or traditional healers to physiotherapy.	
i	You were uncomfortable to treatment patients who always insisted on receiving massage therapy only from you.	
j	Encountered referring medical professions unwilling to consider physiotherapy practitioner's impression on patient's diagnosis hence delaying treatment.	
k	The patient refuses a treatment programme that could be beneficial in preference for treatment of their choice against your advice.	

29 How have you found handling the dilemmas encountered in management of patients with LBP?

a) Difficult ☐
b) Very difficult ☐
c) Easy ☐
d) Very easy ☐

SECTION C: IMPACT OF ETHICAL ISSUES AND TRAINING ON PHYSIOTHERAPY PRACTICE

(Tick correct response according to your opinion and/or experience)

Impact of ethical issues on physiotherapy practice

30 Physiotherapy practitioners often face ethical issues and dilemmas that affect their efficiency and effectiveness in managing LBP.

a) Disagree ☐
b) Strongly disagree ☐
c) Agree ☐
d) Strongly agree ☐

Impact of training on physiotherapy practitioner's abilities to deal with ethical issues.

31 Your physiotherapy training adequately prepared you to handle ethical issues encountered in management of patients with LBP.

a) Disagree ☐
b) Strongly disagre ☐
c) Agree ☐
d) Strongly agree ☐

32 Physiotherapy practitioners would benefit from further training in ethics and professional handling of ethical issues.

a) Disagree ☐
b) Strongly disagree ☐
c) Agree ☐
d) Strongly agree ☐

APPENDIX (VI): REQUEST FOR PERMISSION (INSTITUTIONAL LETTERS)

The University of Zambia - SOM
Department of Physiotherapy
P.O.BOX 50110
Lusaka

January, 2013

The Head
Department of Physiotherapy
University of Zambia
Lusaka

Dear Madam,

RE: REQUEST TO COLLECT RESEARCH PROJECT INFORMATION

I am a Master of Science in Physiotherapy Orthopaedics student at the University of Zambia, School of Medicine. In partial fulfilment of the requirements of this program, I am required to conduct a research study.

The aim of my study is to explore and provide insight into the nature and scope of ethical issues and dilemmas encountered by physiotherapy practitioners in Lusaka, managing patients with Low Back Pain. The study will also determine whether physiotherapy practitioners are adequately prepared in training to handle ethical issues encountered in clinical practice. The study will inform physiotherapy trainers and form a base for further research..

I therefore, request your permission to collect information from your curricula document on the contents of topic or course in Ethics taught to students in training.

Your favourable response will be greatly appreciated.

Yours faithfully,

Kangwa M Chileshe

MSc PT-ORTH STUDENT 2011/2013

The University of Zambia - SOM
Department of Physiotherapy,
P.O.BOX 50110
Lusaka

January, 2013

The Head of Section
Evelyn Hone College
Physiotherapy Section
Lusaka

Dear Madam,

RE: REQUEST TO COLLECT RESEARCH PROJECT INFORMATION

I am a Master of Science in Physiotherapy Orthopaedics student at the University of Zambia, School of Medicine. In partial fulfilment of the requirements of this program, I am required to conduct a research study.

The aim of my study is to explore and provide insight into the nature and scope of ethical issues and dilemmas encountered by physiotherapy practitioners in Lusaka, managing patients with Low Back Pain. The study will also determine whether physiotherapy practitioners are adequately prepared in training to handle ethical issues encountered in clinical practice. The study will inform physiotherapy trainers and form a base for further research..

I therefore, request your permission to collect information from your curricula document on the contents of topic or course in Ethics taught to students in training.

Your favourable response will be greatly appreciated.

Yours faithfully,

Kangwa M Chileshe

MSc PT-ORTH STUDENT 2011/2013

The University of Zambia - SOM
Department of Physiotherapy
P.O.BOX 50110
Lusaka

January, 2013

The Medical Superintendent
Levy Mwanawasa General Hospital
P.O. Box 310084
Lusaka

U.F.S: The Head Department of Physiotherapy UNZA

Dear Sir,

RE: REQUEST TO COLLECT RESEARCH PROJECT INFORMATION

I am a Master of Science in Physiotherapy Orthopaedics student at the University of Zambia, School of Medicine. In partial fulfilment of the requirements of this program, I am required to conduct a research study.

The aim of my study is to explore and provide insight into the nature and scope of ethical issues and dilemmas encountered by physiotherapy practitioners in Lusaka, managing patients with Low Back Pain. The study will also determine whether physiotherapy practitioners are adequately prepared in training to handle ethical issues encountered in clinical practice. The study will inform physiotherapy trainers and form a base for further research.

I therefore, request your permission to conduct a focus group discussion with physiotherapy practitioners in your reputable institution at the boardroom in February 2013.

Your favourable response will be greatly appreciated.

Yours faithfully,

Kangwa M Chileshe

MSc PT-ORTH STUDENT 2011/2013

The University of Zambia - SOM
Department of Physiotherapy
P.O.BOX 50110
Lusaka

January, 2013

The Permanent Secretary
Ministry of Health
Ndeke House
Lusaka

U.F.S: The Head Department of Physiotherapy UNZA

Dear Sir,

RE: REQUEST TO COLLECT RESEARCH PROJECT INFORMATION

I am a Master of Science in Physiotherapy Orthopaedics student at the University of Zambia, School of Medicine. In partial fulfilment of the requirements of this program, I am required to conduct a research study.

The aim of my study is to explore and provide insight into the nature and scope of ethical issues and dilemmas encountered by physiotherapy practitioners in Lusaka, managing patients with Low Back Pain. The study will also determine whether physiotherapy practitioners are adequately prepared in training to handle ethical issues encountered in clinical practice. The study will inform physiotherapy trainers and form a base for further research.

I therefore, request your permission to collect information among physiotherapy practitioners in Lusaka.

Your favourable response will be greatly appreciated.

Yours faithfully,

Kangwa M Chileshe

MSc PT-ORTH STUDENT 2011/2013