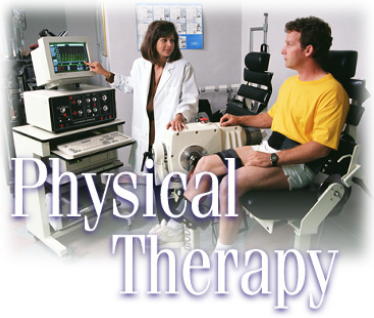
Physical Therapy Practice; Sanitized for Your Protection?

A Theological Analysis by Lisa T. Azzam

SECTION I: THE PROBLEM

INTRODUCTION



Changes in the health care system during the past decade have had an impact on all health professionals. This paper will specifically deal with these changes and their impact on the profession of physical therapy. However, in order to understand the constraints that the medical system and recent changes impose on physical therapist, it is important to define who they are, what they do and the populations that they serve. (Attached picture taken from http://www.pchonline.org/Directories/PhysicalTherapy.html, 2/4/05).

According to the American Physical Therapy Association website (1) "Physical therapists (PTs) provide services aimed at preventing the onset and/or slowing the progression of conditions resulting from injury, disease, and other causes. The physical therapist provides these services to people of all ages who have functional conditions resulting from back and neck injuries, sprains/strains and fractures, arthritis, burns, amputations, stroke, multiple sclerosis, birth defects such as cerebral palsy and spina bifida, injuries related to work and sports, and others."(1) There are over 120,000 licensed PTs in the U.S. today." (1) Physical therapists have a high level of education. A post-baccalaureate degree from an accredited program is the minimum requirement. At this point, the profession is transitioning to the Doctor of Physical Therapy (DPT) degree.

This is a 6-7 year program, depending on the academic institution. Following graduation, PT's must pass a national licensing exam in order to practice. In terms of salaries, "The median salary for a physical therapist is $52,000 depending on position, years of experience, degree of education, geographic location, and practice setting. (1) Practice settings are diverse and include: outpatient clinics, home-care, inpatient rehabilitation, acute care, and extended care facilities, research and academic centers, schools, industrial and fitness facilities. For the purpose of this paper I will focus on examples from acute and sub acute rehabilitation facilities.

For PT's, new models for practice, caseload management, insurance administration, cost containment as well as productivity measurement are emerging. Daily challenges include computer-based charting, stringent billing standards, downsizing or merging of departments and escalating documentation and administrative duties. All of this is in the face of ever changing and difficult to interpret government (i.e., Medicare/Medicaid administration) and private insurance regulations (i.e., Home Maintenance Organizations [HMOs] (2)). PT's spend more time on administrative and management duties and less time on direct patient care. This has led to a redesigning of the roles and responsibilities of PT's in many clinical settings. (Attached picture taken from http://wchs-wy.org/manor.html, 2/4/05).

There have been few studies on the effect of these occupational stressors on physical therapists. Broom and Williams (3) identified clinical workload, paperwork, escalating professional expectations and reduced resources as causative factors of job

stress. Deckard and Present (4) investigated the relationship between what they characterized as role stress and physical therapists. They defined *role stress* as a struggle between overall job responsibilities and physical therapist's perceived professional responsibilities. This study found a significant association of role stress to diminished physical and emotional well-being of physical therapists. A study by Lopopolo (5) investigated the changing role of PT's during restructuring of a large teaching hospital. The author found that changes in the role of PT's occurred primarily in the patient interaction and direct patient care arenas, and that nearly 50% of therapists surveyed felt that their practice was "moderately to significantly impacted." A drawback to the latter study was the participants themselves, which consisted of managerial level PT's with the exclusion of therapists actively involved in patient care.

Although these studies are limited in number and scope, they all point to the probability of burnout among PT's. One specific study of physical and occupational therapists (6) in 2002 looked at the incidence of burnout among these professionals and the work factors related to emotional exhaustion (EE), depersonalization (DP) and personal achievement (PA), elements that are contained in the Maslach Burnout Inventory. In over 300 therapists in several clinical settings throughout New York City, overall MBI scores showed high rates of EE and DP and low rates of PA. These scores were higher than the norms reported in previous studies for the general population and other human service professionals. Another study looked at the specific factors associated with burnout at rehabilitation hospitals in Massachusetts (7) This group also used a survey method including the MBI, demographic data, and questions designed to assess personality and the work environment. Donohoe et al found that 46% of therapists scored

high on EE, 20% scored high on the DP scale and 60% scored low on the PA scale of the MBI. As a whole, the sample demonstrated moderate burnout. Three significant factors leading to burnout were cited; communication /connectiveness, achievement and time constraints which accounted for 69% of the variability in EE and 73% of the variability in PA and DP.

From the latter study, it appears that Productivity demands (identified in the category of time constraints) are a significant work stressor for physical therapists. As such it is a contributor to burnout. Burnout is a serious concern to the individual, the patient and the field of PT. It can lead to "psychosomatic complaints, work-associated withdrawal behaviors and ultimately, a decreased quality of care" for patients (8). Another research report synthesized survey results from therapists in a large urban medical center and asked "Over the past 4 years and many changes in your work environment, what has it been like for you as a clinician?" (9) Four common themes emerged among these therapists described as loss of control, stress, discontent and disheartenment. Several direct quotes from the surveys, specifically in terms of productivity, demonstrate these themes:

"I have a constant number of new patients that roll onto my schedule every week whether or not I'm done with the ones that I had weeks ago….that constant, air traffic controller feeling can make every minute count at work but you still can't handle the volume of patients coming in"

"I think one of the things is you feel as if you have lost control as a clinician in deciding what happens with you…everything is based on how often you can see this patient and how much time you can spend with them….Sometimes you come in, and you feel you can spend an hour with a patient, but you're not encouraged that way."

"There's a lot of tension, trying to run on time, trying to give patients the best care, and trying to do everything I can do to give that care. I've already made the decision it's not

going to get written up until later (patient notes), which is a stressor, but just trying to sit down (to do it) can be pretty stressful. I can't even go to the bathroom when the day gets that hectic. Lunch—I've never eaten lunch away from my desk. I'm doing documentation…"

"There are days when you're seeing so many people you are going crazy, and it doesn't get better and better, it only gets worse and worse, and you feel like you're mentally going mad and going nuts and you're going to…crack……"

PRODUCTIVITY

Brooks Rehab Solutions, a company that develops productivity benchmarking tools for PT (10), defines productivity as "an objective comparison and quantifiable data in order to define current rehabilitation performance across a broad spectrum of indicators." These indicators include staff utilization and productivity, marketing, revenue and expenses. Specific items of Productivity "benchmarking" are hours of direct patient/client care, number of patients/clients seen, number of visits completed, and total billable hours. Productivity benchmarks vary from facility to facility. Examples of productivity expectations are ~ 15-20 patients a day in an outpatient setting and 7-7.5 hours of patient treatment for acute care therapists. Therapists in acute rehabilitation facilities may be required to treat 7-8 patients a day for 1 hour for each patient. These ranges are considered reasonable for an eight-hour workday. According to the American Physical Therapy Association (APTA) *Practice Profile Survey* (11), productivity standards were found in all PT practice settings in the United States; the highest in extended care facilities / nursing homes (67.5%), acute care hospitals (65.1%), sub-acute/rehab hospitals (62.5%), and private and hospital-based outpatient facilities or clinics (59.3%). Anecdotally, all hospitals and facilities within Massachusetts hold their

physical therapy employees accountable to productivity standards. (Attached picture taken from http://www.jfkmc.com/CPM/Physical%20Therapy.jpg, 2/4/05).

PROS AND CONS OF PRODUCTIVITY STANDARDS

Charles M. Magistro, PT, a former president of the APTA cites the positive results that occur with productivity measurement. "In terms of productivity, it is critical for managers to be able to evaluate their staffs to better control their costs, not only from a mechanical sense of being productive, but also from a sense of what you are doing while being productive….if a PT has deficiencies, those can be identified and ameliorated.." (Attached picture taken from http://www.bizstats.com/graph.gif, 2/4/05).

Therefore, comparative numbers are considered critical in establishing performance baselines and goals and estimating potential return and risks on investment and identifying where better practice can be found (2). It is interesting that these statements focus on finances and investment *first*, with practice quality as an apparent afterthought. Productivity benchmarking may also be used to show how a practice or facility compares and ranks them to other similar groups. The good news is that you can compare and contrast your performance against that of others. The bad news is that these numbers are used by insurance brokers and government agencies to determine who and what agencies will receive large health care contracts. It also serves to enhance a beat the clock mentality "I can do it in 2 treatments" which sets a precedent for the rest of the

field. The latter is often not based on best practice or objective evidence from the field. Therefore it is a dangerous precedent for patient care.

Opponents of productivity standards point out that results have often been used not as learning tools of a means of quality improvement, but as "inflexible devices to punish PT's whose numbers aren't as "good" as they should be (11)." Garrick Hyde, (10) a consultant of a business firm that works with PT departments to improve their operations, confirms this fear. "Usually I'm presenting the results to hospital management. I give them a little lecture on the "do's and don's" of benchmarking. I tell them not to use benchmarking punitively. If there are opportunities, there may be a reason why a department comes out at high cost. Employees (therapists) may not be lazy or inefficient. I encourage them to withhold judgment until they uncover all the root issues. That's hard for many clients. Once they get the report in hand, they want to use it as a budget. That doesn't work. It builds animosity and resentment. You've got to consider the culture of the organization and the individual characters of the people you're dealing with, and couple the bottom line with some element of humanity." Other opponents of productivity benchmarking claim that the "humanity" of the employee is incalculable, that each therapist is unique (10). Others claim that there are too many factors involved in a busy work day to estimate or set appropriate productivity standards (10, 11).

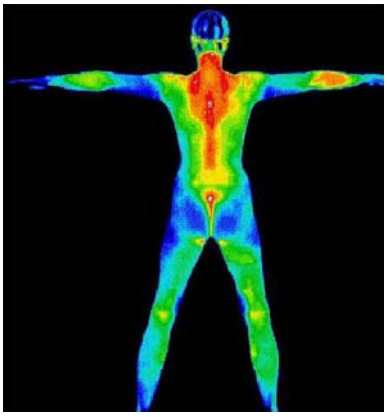
HYPOTHESIS

Patient productivity quotas create an assembly line versus a patient focused mentality. I assert, on a theological basis, that an emphasis on patient productivity in physical therapy is demeaning to therapists and potentially harmful to patients. Although I focus on

Christian health care workers, specifically physical therapists, many principles apply to anyone who is a "spiritually-based" healthcare practitioner.

SECTION 2: THEOLOGICAL ANALYSIS

Honoring the Body



The spirit, emotions and intellect are each innate, intangible qualities of the human condition. The physical body is the visible, tangible container of all three. The body manifests outward behavior, thought and feeling through speech and activity. The physical body is the instrument through which the mind, emotions, and spirit take in and process environmental stimuli and nourishment to provide physical growth, intellectual knowledge, and spiritual and emotional development. The body also receives sensory stimulus for vision, hearing, and perception of the environment that facilitates dreams, imagination and faith. (Attached picture taken from http://www.newdynamic.com/body%20elements.htm, 2/4/05).

Biblically, the body is the "temple of the Spirit (I Cor.6.19)." As the receptacle of the spirit, the body ought never to be degraded or exploited. As the place where the Divine presence dwells, the body is sacred, and should require nothing less than honor. Stephanie Paulsell, author of Honoring the Body; Meditations on a Christian Practice (12) reiterates this concept and writes, "The practice of honoring the body challenges us to remember the sacredness of the body in every moment of our lives…Because our bodies are so vulnerable, we need each other to protect and care for them." As physical

therapists we are responsible to protect and care for our patients. We specifically honor the body by properly draping during an examination, providing therapeutic touch and healing and acknowledging the pain and suffering of the body as well as facilitating its innate power of healing. The practice of honoring the body is born of the confidence that our bodies are made in the Image of God our Creator and through God's own goodness and the knowledge that our bodies are worthy of blessing and care.

In the Christian tradition, Jesus' resurrected body teaches us that the body matters and shows us the beauty God intends for all bodies. However, Jesus' broken body also helps us to see Jesus in every sick, wounded and exploited body we encounter. In honoring the sick or broken body, we honor the spirit, which dwells inside. They cannot be separated. It is therefore little wonder that we, as Christian health care professionals, strive so diligently to save the body from sickness, suffering and/or death so that we may continue to sustain this vessel.

Individuals vary in their need for physical, emotional, spiritual and intellectual support. In the fast paced world of hospital care and the short-cuts often required to complete a day's worth of productivity, it is rare to do all that is necessary in terms of honoring the needs of each individual. Chronic time constraints prevent therapists from honoring the body and treating it as sacred. This applies not only to our patients, but also to our colleagues and us. As therapists we must treat the body as worthy and deserving of our utmost care and compassion. This takes time however, which is a precious commodity in the workplace.

Vocation as Covenant

Physical therapists are engaged in vocations, not just occupations for which they are specially trained. Physical therapy is a sacred ministry of health care or health promotion provided to persons both sick and well, who require care giving, support, advocacy and/or or education to assist them in achieving, regaining, or maintaining a state of wholeness, including wellness of body, mind and spirit.

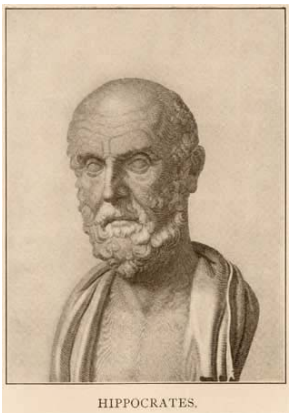
Furthermore, PT is a *covenant* between the patient and the therapist and the therapist and God. By covenant, I mean a binding agreement or contract to do everything in the best interest of the patient. This entails practicing ethically, morally and legally in every circumstance and placing the well-being of those we serve above our own self-interests. (Attached picture taken from http://www.utmem.edu/allied/physical_therapy_faq.html, 2/4/05).

One critical and constant dimension of the therapeutic relationship relates to the degree of trust engendered between interacting parties. The element of trust is lived out in terms of this covenant relationship. In this covenant there is no condition put on faithfulness. It is the unconditional commitment to be of service to God and our patients. Given this understanding, the covenant relationship between therapist and patient, can be viewed as sacred.

Mary Elizabeth O'Brien RN, in her book, *A Nurse's Handbook of Spiritual Care, Standing on Holy Ground* (13), also makes this connection to covenant and begins her

book with the quote from the book of Exodus 3:5 "Remove the sandals from your feet, for the place on which you are standing is holy ground." She states "Perhaps no scriptural theme so well models the spiritual posture of nursing practice as the Old Testament depiction of Moses and the burning bush. In the biblical narrative, God reminded Moses that, when he stood before his Lord, the ground beneath his feet was holy. When the nurse stands before a patient, or a family member, God is also present, and the ground on which the nurse is standing is holy. For it is here, in the act of serving a brother or sister in need, that the nurse truly encounters God." Physical therapy practice can also be seen in this Biblical metaphor. It seems appropriate to envision practicing nurses, therapists and other health care workers coming together with their patients in caring and compassion, as standing on holy ground. God frequently speaks to us from a burning bush; in the fretful whimper of a child in pain, in the anxious questions of a spinal cord injured patient, and in the moans of a fragile elder. If we take off our shoes, or in other words, let down the barriers to humbly serving, then we realize that the place where we stand is holy ground and we will respond to our patients as we would wish to respond to God in the burning bush. To complete the 'holy ground' metaphor, we must have time to consecrate the ground, to stand upon it with full attention toward our healing purpose with time to enter into this healing relationship with the patient and The Great Physician. However, there are not only personal barriers for the caregiver to overcome in order to "stand on holy ground" but there are organizational and time barriers. Rather than standing we are running, and sometimes running in place, covering no ground at all.

Oaths


HIPPOCRATES.

The commitment and faithfulness of the covenant between the public and the PT may be formally declared or promised in the near future by a Physical Therapy Oath or Pledge to be taken by PT students upon graduation. Oaths and pledges are not a new concept to the medical field. The Hippocratic Oath (14) has been a standard for new physicians since the 4th century B.C. E. (*See the original and the modern version of the Hippocratic Oath attached* [15]). It has been modified and modernized over time. Two of the largest concerns of the Oath is that it encourages, or demands, protection for fellow physicians and in a larger realm the medical profession as a whole (even when it may not be warranted ethically or legally) and that non-maleficense or the concept of "do no harm" (15) is not actually within the text. In fact, the inferences to non-maleficense are cited later in the Oath and seem to be less of a priority. These concerns are evident today, in the gestalt of health care. Physicians, like other health care workers, feel the pinch of cost containment, and are encouraged to ration medical care. Physicians are even monitored on a monthly basis in large metropolitan hospitals for services and tests that they prescribe (including PT). These doctors feel that their practice is significantly limited by systemic, financial and insurance factors. Overall, these constraints lessen the quality of care for patients. It is interesting to note that the Oath of Hippocrates appears to work in conjunction with these constraints to reinforce them. As a profession that will newly write an Oath or Pledge, PT's must take their stand to insure that any formal promise to

God and the public should not follow suit. (Attached picture of Hippocrates taken from http://www.ironorchid.com/clipart/persons/Hippocrates.htm, 2/4/05).

Florence Nightingale, the founder of the Nursing profession and the assumed author of another prominent medical pledge (16), was a Christian who believed that spiritual and professional practice could not be separated. She insisted that all trained nurses lend a spiritual component (not necessarily a religious or Christian one) to their clinical practice. She emphasized that her nurses should be "handmaidens of the Lord" and that they should allow patients to "step into the Lord's Infirmary" for restoration and healing. Although dated, the Nightingale Pledge below aligns professional with personal commitments, which is a higher aspiration for therapists to achieve.

Florence Nightingale Pledge

"I solemnly pledge myself before God an in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care." (Attached picture of Florence Nightingale taken from http://www.florence-nightingale.co.uk/flo2.htm, 2/4/05).

The possibility of a Physical Therapy Oath or Pledge has sparked controversy among physical therapy educators (APTA Educational List serve communications Jan-Feb 2004). Many prefer that the graduating students take a pledge rather than an oath. Within a strict definition (unlike that of the Nightingale Pledge) of a pledge, one promises to do something, perform an obligation or duty or refrain from doing something to the audience/public to which you make the pledge. Alternatively, to take an oath, one makes the same promise as stated in a pledge to the audience and the public, but one often calls upon God, or some other sacred body/object as a witness (17). It is not unusual that in more secular times like ours, therapists are concerned about inviting a "Higher Power" into their practice. However, this is also surprising in light of the more "holistic" approach to patient care that PTs often profess. This holistic component includes spiritual growth and support of both the caregiver (in order to relate to and provide spiritual care) as well as the patient. This spiritual development would include whatever the term "spiritual" entails for the patient and therapist.

If a PT Oath is instituted, and this seems more likely than a pledge according to a recent APTA delegates conference (18) it would serve to deepen the professional and ethical commitment of the therapist to both God and the patient. This hopefully would elevate consciousness regarding our duties and obligations. On the other hand, an Oath would serve to draw closer attention to the discrepancy between these duties and obligations and the real time possibility of PTs to perform them adequately.

Code of Ethics (See attached)

The Preamble to the Physical Therapy Code of Ethics (19) states that "all physical therapists are responsible for maintaining and promoting ethical practice. To this end, the physical therapist shall act in the best interest of the patient/client." The case below will be analyzed according to the Code of Ethics and PT Department Policy/Procedure. As will be evident, these two often present ethical dilemmas for the PT.

General Background; You work on a rehabilitation floor in an extended care facility. You pick up your caseload schedule in the a.m. All of your patients have been assessed for the time allotted to them for physical therapy treatment based on the Prospective Payor System (PPS). This means that each patient, according to diagnosis, insurance type and other factors is assigned a specific number of minutes for each type of therapy allowed per day for a certain number of days. Hospital therapists in managerial positions determine these patient treatment allotments. They make these assessments after the treating therapist has evaluated the patient and documented the approximate length of time needed to achieve the desired functional outcomes (i.e. Independent walking with a cane) to hopefully return home. According to the PPS, treatment sessions range from 15 minutes to 60 minutes, once or twice per day for 4-7 days a week while hospitalized. Therefore you have a schedule that consists of ~16-20 patients, all allotted specific treatment times. Some of these patients have the same diagnosis, but with different insurance companies (Medicare/Medicaid versus private HMO insurance) the time allotted for therapy may be drastically different.

Specific Situation: Two of the patients that you must treat are in the same room. One of the patients has had surgery for an uncomplicated total hip replacement. You are seeing this patient for the second 45-minute treatment session of the day. In the morning, this patient did very well and you wonder whether the patient actually *needs* this second treatment. But, after all, the patient's insurance company allows this time. Actually, this could be considered a case of "over-utilization" of services (**Principle 3 *in conflict with* Principle 4**). But, after all, the patient has paid for, and does deserve the insurance benefits (**Principle 1 and Principle 3 *in conflict with* Principle 4, 7 and Principle 9**). In addition, staff therapists are "encouraged" to bill for all available services that insurance allows for the patient ***(*Principle 4 and Principle 7 *in conflict with* Principle 2 and 3*)***. If not given the services for that day, the patient will lose these billable treatments and services that cannot be delivered on a later date/time ***(*Principle 1 *in conflict with* Principle 7*).*** For hospital managers, this is conveyed as a "win-win" situation for both the hospital and the patient. In the next bed, is Mr. G., a patient with Multiple Sclerosis. This gentleman is very involved physically and cognitively. His PPS designation allows him 15 minutes of treatment. You decide to start with this patient first. You must help him to ambulate with his crutches (attached picture taken from http://www.stkate.edu/minneapolis/pt.html, 2/4/05). He hasn't done so in two weeks. He also uses two braces on his legs. By the time you have explained the treatment and donned the braces, the 15 minutes are up. However, you now have Mr. G. ready to start the treatment. You decide that it is out of the question not to complete the session ***(compliant with* Principle 1, 2, 3,6 and 9*).*** You

at least need to assess his ability to ambulate. Forty five minutes later, you are returning Mr. G. back to bed, removing his braces and leaving him in a comfortable position. You feel good about the treatment. You did what was best for the patient and you performed your professional duty ***(compliant with* Principle 1, 2, 3,6 and 9*)***. The problem is, you ended up giving Mr. G. 45 extra minutes, in addition to the 15 minute limit he was "legitimately" allotted initially. These additional 45 minutes are not billable to the patient's insurance ***(violates* Principle 3*)***. This time does not include the chart review prior to treatment **(*compliant with* Principle 8),** the documentation of the treatment **(*compliant with* Principle 8),** and speaking to other health care professionals about discharge planning or medical status ***(compliant with* Principle 8 and 11*)***. This time is not credited to the therapist as "direct, patient care", but "indirect time" [As a matter of course therapists are assessed on their yearly performance evaluations by their ability to consistently meet these productivity standards which are based purely on direct, billable time.] Furthermore, you are now at least one hour behind schedule. You still need to treat the less involved patient in the next bed for 45 minutes (**Principle 3 *in conflict with* Principle 4**), which, in your professional judgment is unnecessary. By this I mean, Mr. L. can easily walk with a nurse or an aide, this is not specifically a "skilled" Physical therapy treatment.

Options:

1. Give Mr. G., the patient allotted 15 minutes as much treatment time determined by your professional opinion ***(*Principle 3 *in conflict with* Principle 5**).

2. Stay late to give other patients what they "deserve" in terms of insurance **(*compliant with* Principle3, However, if this is a chronic problem exhausts the PT over time)**

3. Treat the second patient for the 45 minutes allotted to him by insurance regulations **(Principle 3 *in conflict with* Principle 4)**

4. Treat *according to the needs of each patient.* AKA, what PT's used to do. In this case it ***violates*** **Principle 3** for both patients. It also pits **Principle 4, or the autonomy of the therapist *against* Principle 3)**

This is one true case of one therapist in the field. These cases are multiplied many times over. Therapists often feel helpless in situations where their autonomy, or that of their patients appears to be in opposition to doing the best for the medical institution, that are in turn financed by insurance companies. This sets up inherent conflicts of interest. In Principles 9, PT's are held accountable for the "protection of the public and the profession from unethical, incompetent and illegal acts. In Principle 10, PT's are required to "endeavor to address the health needs of the society". In contrast to these principles, it seems that the trajectory of the profession, is to create a type of rationing system, in which the best is done for the most. On the surface this seems to be a reasonable and fiscally sound goal. However, as this case study demonstrates, there are "out lyers" in the system; the sickest, the indigent, the uninsured, the elderly and children, to whom we must be responsible, even at a cost to ourselves as workers within the system. In addition, this rationing of care does not honor the patient or God.

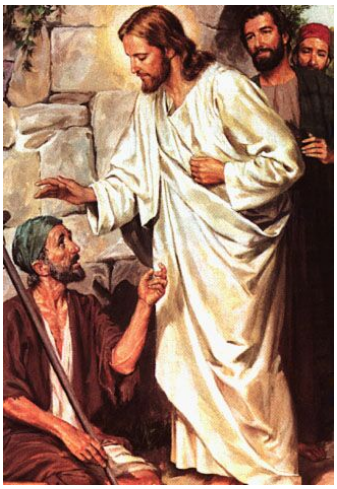
Despite the outlined dilemmas, many PTs try to work positively within the system to give the best care possible. Often it means long hours, missed lunches and piles of administrative work. As professionals, rather than salaried workers, PTs are not

compensated financially for any extra hours worked. Therefore they often feel their efforts are unappreciated and simply “expected”. This is a large factor of emotional exhaustion and depersonalization. Many departments have also cut down on education and rounds in order to meet the ever-burgeoning demands of the job. This makes compliance with Principals 5, to “maintain professional competence” and Principle 6, to “promote high standards for PT practice, education and research, difficult if not impossible. (Attached picture taken from http://www.systoc.com/Tracker/Winter01/BillFundamnt2.asp, 2/4/05).

Therapists are also inculcated professionally to avoid conflict and complaints. They are gauged and assessed on their job performance early on as students during clinical affiliations and later, on an annual basis as professionals. Categories that are contained in performance evaluations (anecdotal experience) include: Decision Making and Clinical Judgment, Utilization of Resources, Time-Management, Documentation, Productivity and Professionalism. The latter emphasizes, cooperation, maturity, positive attitude, adaptability and the ability to work well on a team. A high value is placed on this professional component of behavior and communication. Another factor of burnout for therapists then, is that they cannot bring legitimate complaints or concerns (especially ethical ones) to their supervisors or managers for fear of being labeled as non-professional or a “trouble-maker” or a therapist who promotes discontent and bad morale. This ultimately affects not only the therapist’s performance evaluation but also subsequent promotions or merit raises. If a therapist ultimately leaves a facility, it may

also affect the ability to obtain positive job references. So, legitimate concerns, when voiced, may be seen as complaining, and unfortunately may be tied to negative consequences.

The Imitation of Christ



For many Christian health practitioners Jesus is the ultimate role model; as Healer, as Servant and as Wisdom. Characteristics that have been attributed to the Christ can be endlessly acted out in practice including, integrity, accountability, mercy, forgiveness, compassion and love. In short, one can ask of clinical practice, as one youth movement asks, "What would Jesus do?" (Attached picture taken from http://www.montclair.edu/orgs/newman/newman.html, 2/4/05).

Unfortunately, there is often a "disconnect" between what Jesus would do in the situation and what actually occurs. This leads to feelings of guilt or hopelessness. One feels that he or she can never live up to a semblance of Jesus (the best we can do) in the workplace. This is where forgiveness and grace come into play. We forgive ourselves for the times when we fall short of the goal. We accept that Jesus forgives us. We forgive the people, places and things that we believe are boundaries to effective care. God instills in us the grace to keep trying to achieve a likeness to Christ in our servant hood. Grace energizes us to do the extraordinary in exhausting circumstances. This defines a good day in the neighborhood. But what happens when we cannot be forgiving? Or when we cannot feel God's grace or Spirit? What happens when we can no longer transcend our

circumstances to find God there in the transcending experience? Usually, short of burnout, I have found, somehow, the strength to begin the cycle again; forgiveness, grace, transcendence, exhaustion, discouragement, hitting bottom; forgiveness, grace, transcendence… Finally, I begin to accept that things may not change, they indeed may become worse, but that my "ultimate concern" must be the covenant that I have made to God to care for God's people.

The Holy Spirit

Through this vocation, Christian PT's exercise discernment regarding treatment and decision making that is guided by the Holy Spirit. Some may call this the art or intuition of practice. For us, however, it is the Holy Spirit. The "gift of healing" also comes from the Spirit (I Cor. 12.28). The Holy Spirit informs our minds and hearts and gives us the words to speak when our own seem limited or futile. The Spirit also enables us to offer comfort and healing in the face of suffering. It is the source of our strength. The Spirit accompanies us to dark and scary places; to medical codes, to hospital rooms and Intensive care Units where the suffering is palpable and humans may not be recognizable as humans. The Spirit accompanies us. She is there. We remember in these moments "I will leave you or forsake you". Sometimes though, we can't focus on the present moment. We can't focus in on the Spirit, or feel her. There is too much to do and we are too anxious that we can't possibly do enough to minister healing to all these patients. Like a blood pressure machine, time is a Spirit-restricting tourniquet. We search for ways to prevent the final choking off of our

spiritual circulation. Sometimes we are successful, the tourniquet is released and the flow of the Spirit is restored. Other times we are not successful. (Attached picture taken from http://www.pjpres.org/Healing_and_Wholeness.htm, 2/4/05).

Ultimate Concerns

Finally**,** there seems to be a discrepancy between the ultimate concern of the US health care system compared to the ultimate concerns of patients and PT's. Although touted as altruistic, from the "inside" the health care system seems hostile. Look at the mission statements below of several "no-name" metropolitan hospitals:

Mission Statements

1. To provide the highest quality care to individuals and to the community, to advance care through excellence in biomedical research, and to educate future academic and practice leaders of the health care professions. research, and to educate future academic and practice leaders of the health care professions.

2. (Geared to professional staff) The mission of XXXXXXXX is to support, promote, and develop innovative programs and models for the dual activities of teaching and research at academic medical centers. The XXXX will provide intellectual leadership, state-of-the-art facilities, and faculty and staff resources to support the education and training of medical students, residents, fellows, and other trainees as well as the career development and mentorship of faculty. The XXXX will play a broader role in fostering the mission of academic medical centers around the country and throughout the world by training tomorrow's leaders in education and research and by assuming a leadership role in addressing and helping solve the challenges facing academic medicine.

3. Facility XXX enables persons to achieve their highest level of function, independence and performance.

- We provide a full continuum of services, long-term acute care and community based rehabilitation services.
- We contribute new knowledge and treatment approaches to rehabilitation and disease and injury management through research and outcome studies.
- We educate future rehabilitation specialists, including physicians, nurses, therapists and other allied health professionals.
- We advocate for persons with disabilities and long-term illness.

- We support the mission of Partners HealthCare System and collaborate with other healthcare providers.

On paper, the mission statements of Institutions 1 and 3 are geared toward excellence in patient care first and foremost, followed by academic and research endeavors. The motivations here appear honorable on the part of those establishing the mission statements. However, in actuality, mission statements lose something in translation. Often "big" money, usually externally funded, is given to the research and academic endeavors of an institution. Less money is provided to the direct patient care areas. Of course the patient benefits from the research and academic advances of the organization. Eventually. But this is also balanced with the motivation to advance the academy and research program versus excellence of patient care on a day-to-day basis. So the motivating factors of the institution skew the benefit to the patient. On a positive note, more hospitals are conducting employee and patient satisfaction surveys and instituting appropriate changes. In addition, hospitals are also developing what are called Core Values as well as mission and vision statements. For example, at Spaulding Rehabilitation Hospital in Boston, these Core Values include; Teamwork, Patient Focus, Ethics, Communication, Diversity and Cultural Sensitivity among others.

But it isn't enough to state the mission or core values of the system. Institutions may have divided loyalties but they "cannot serve two masters," namely money, power and prestige on one hand and quality of patient care on the other. These are natural enemies. There must be accountability on the part of the institution to insure that there is a trickle down effect of

the mission into the working operations of the system. Only in this way can the goals of these documents truly be aligned with actual patient care and the needs of the work force. (Attached picture taken from http://www.hooverdigest.org/042/alper.html, 2/4/05).

Another positive move is that more employers are directing their marketing and advertising to potential health care employees by stressing putting the 'care' back into health care. Employees are aware that therapists want to work for and in an environment that is empowering to them and to their patients and that fosters and supports patient care and professional growth. Again, marketing and spin cannot guarantee positive results, but it is evident that employers are aware that therapists are looking for new and different opportunities and approaches to health care.

Conclusion

In the beginning of this paper, I asserted that on a theological basis, an emphasis on patient productivity in physical therapy is demeaning to therapists and potentially harmful to patients. I have outlined factors that support this hypothesis; vocation as covenant and service, as worship and imitation of the Christ, and practice that is informed by the Holy Spirit. I have also purported that ethical dilemmas place therapists and patients in harms way. Barriers to authentic expression of therapists as persons and practitioners have also been delineated.

Under these multivariate circumstances, it is difficult for PTs to satisfy all the needs of those we serve. God wants justice for all of God's creatures, not just some. God wants us

to honor and to heal the body that contains the Spirit of God. God wants us to use the "mind of Christ" and discern what each individual truly needs. God wants us to exercise Christ's compassion and mercy, which we don't always have time to do. God wants us to exercise our gifts, which for the most part is limited by the work environment and systemic restraints. God wants us to be true to ourselves.

The question remains, can we work within the system and attain and do all of these things that honor God? It depends on our ability to transcend our limitations. Each individual knows where his or her own limits of transcendence lie. Objectively, according to the Maslich Burnout Scale this occurs when the individual achieves a high amount of Emotional Exhaustion and Depersonalization and a low level of Personal Achievement. Therapists quoted in the Introduction of the paper had all three of these scenarios (9). However, these same therapists were able to "find the silver lining" in the situation and prevail in often overwhelming circumstances. It is interesting to note that one of the prevalent factors that therapists attributed to this attitude was some type of religious affiliation. This may be proof of their ability to theologically transcend their circumstances and find ways to authentically serve themselves and their patients.

Yes, productivity benchmarks in health care are demeaning and potentially dangerous to both therapists and patients. For this reason, the medical system gives us tremendous opportunities for transcendence. Each individual knows when he or she no longer has the resources or Spirit to do so. In fact, the awareness of this boundary line may indeed be an act of transcendence itself.

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