Do You Own Your Practice? Owning Your Decisions and Actions

Good evening. I would like to first thank my colleagues who nominated me for this award, the Awards committee, and the Acute Care Section for this great honor. I have exceptional predecessors and mentors who set the bar very high for me in my professional development and in my preparation for this prestigious award. I appreciate your trust and hope that I will exceed your expectations.

"I am an hourly employee—I own my practice."

I made this statement to a colleague of mine many years ago under the rotunda of the Illinois capital building when we were out en masse trying to lobby our legislators to make unrestricted direct access to physical therapist services the law in Illinois. Interestingly, direct access sparked fear in some therapists who did not want to take the risk of managing a patient without the "OK" of a physician. Although they made decisions as to what care to impart in each therapy session for years, having that requirement of the physician's OK seemingly distanced them from the responsibility of dealing with any potential failure. Owning your decisions and actions requires that you appreciate the depth and breadth of the impact you can and should have on a patient, whether the primary concerns that the patient presents with are those for which the patient was referred to you by a physician, or whether the most important concerns turn out to be those that you uncover during your professional examination and evaluation. Even if a surgical or medical service dictates that the patient should be up in the chair, or walk 3 times per day, or whatever broad-brushed request they may have, you have the responsibility to progress your patient with ongoing measurement of their tolerance. You have your own license that is at risk if the highest level of decision making employed was, "The doctor told me to."

Our profession has developed significantly in our entry-level education and the quality of care, defined by using evidence and tools like outcome measures. Long gone are the hospital admissions for back pain where physical therapists administered Hubbard tank treatments.

In addition, although they are not all perfect measures, and they have to be applied appropriately to have the greatest effect on your clinical decisions, at least there is a strong initiative to figure out what care makes the greatest difference in our patients' lives and uses the fewest resources to gain a successful outcome. The American health care system is the most expensive system when taken as a whole, and the least effective on many measures, when compared with other major industrialized nations.

American Physical Therapy Association's (APTA's) Physical Therapy Outcomes Registry is one initiative that is moving our profession forward to be recognized as the leaders in what we are comparatively the best educated in—that being, the use of prescribed and titrated activity related to disease recovery, prevention, and its use in the management of chronic illness to reduce comorbidities. Our educational programs develop practitioners with an astute understanding of physiology, biomechanics, kinesiology, pathophysiology, you know the topics—you are somewhere along the continuum of either taking the classes right now to you survived them with the help of many and you are now a practicing clinician.

If you were to compare the educational requirements set forth by the Commission on Accreditation in Physical Therapy Education versus the educational requirements of other health professions such as advanced practice nurses, physician assistants, and physicians, you would likely find that their awareness of physiology is similar in many ways to ours, how they apply it is very different. They do not explore the physiologic changes related to exercise as thoroughly as we do in our curricula. So why should we defer the decision as to when a patient is ready to tolerate exercise, and the duration and intensity of the exercise, to a professional less qualified than us? I am not suggesting we physical therapists become "swashbuckling trail blazers" who throw caution aside. No, even more, the approach I am advocating requires that the practitioner who owns her own decisions confers with the other professionals of the team and be the person who determines the duration, intensity, and frequency of the exercise/activity session. It is the responsibility

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of the therapist to inform the team of the rationale that drives her decisions and supports her decisions with evidence. It is the responsibility of the therapist to communicate the exercise response information to guide future medical decisions.

Almost 24 years ago, I started practicing at Rush University Medical Center in Chicago. Yes, I hear your rhetorical question echoing—"Jen, you must have started as a child?" I will quell your curiosity—it is true!

In that setting I have had the diverse patient population opportunities of most major medical centers. We encounter the medically complex, the socially complex, and the complexly complex. Whether I am in one of our adult critical care environments, our very busy joint replacement floor, or our general medical floors where the chronic illness issues are exacerbated by the social issues and the social issues are exacerbated by the chronic illness issues, I (the therapist) am often making very challenging decisions about next levels of care, how to define independence and safety, and what steps need to occur to get the patient to the hospital's endpoint—discharged.

If we only had those challenges before us, we would have more than too much responsibility; but we have other stressors as well.

The most common way that a physical therapist or physical therapist assistant is employed in acute care physical therapy departments is as an employee who answers to a manager within a hospital department. There are potential constraints on professional leeway when you are an employee who may be challenged, for example, to taper the duration of her patient interactions so that she will not cause the department to pay her overtime. Such constraints would not exist if you were in the role of the therapist who owns the practice and all of the decisions. Likewise, as an employee, you are able to distance yourself, if not completely exempt yourself from certain responsibilities like making sure that the business is solvent while still imparting evidence-based care.

Does that employee status subvert the practitioner's possibilities for professional development? I do not think that it does, as long as the practitioner knows that no matter what the productivity or customer service score concerns are for the department, each patient interaction, each professional interaction, each caregiver interaction requires that decisions are made and actions are taken that are all in the best interest of the patient within the constraints of the situation at hand.

One other question is: Must this employee status limit the physical therapist's perception of the onus of responsibility in each individual practitioner? When I ask this, I wonder how each person in the room defines the responsibility. Are you thinking about the immediate ramifications of your actions, for example, the physiologic response, the stability, or fatigue that presents after the intervention? Are you thinking of the potential downstream effects that can be attributed to the care that you offered when the next therapist sees that patient? If yes, are you thinking of 2 hours from then, 2 days from then, or 5 years from then? You are likely considering all of these factors.

In his book, *Becoming a Reflective Practitioner*, Christopher Johns asserts, "Being a reflective practitioner is a way of being in practice rather than something I do—for example, something I write in a journal…reflection is something lived.[1]" I would advocate that the acute care practitioner who is reflective is using an ongoing decision-making process throughout each session with her patients, and/or makes immediate follow-up as she reflects throughout her documentation to look for any disconnects in her plan or in her patient's plan for support or recovery. This practitioner is owning each decision that she makes. The reflective practitioner does not say, "Whatever."

The reflective practitioner understands that the emotional and social challenges of the patient can impact their ability to perform physically and so she adapts and modifies the session tempo and focus, and uses various forms of clinical reasoning, to determine the intensity and sequence of interventions to improve her patient's participation in and tolerance for the interventions. It is daunting to think of the magnitude of what you can *and should* do in each patient interaction in the compressed timeframe of an acute care examination, evaluation, and intervention. It is even tougher to perform the physical tasks well and manage all of that information at the same time while remaining confident and organized to make the patient relaxed and able to maximize their performance.

Does the fast pace of acute care, and the even faster and more dramatic pace of critical care, make it difficult for a practitioner to be reflective and own her decisions and actions? Personally, I came to a point in my practice where I finally stopped blaming the paperwork, or saying, "I don't like working on that floor" and I realized that regardless of where I am working in the hospital, I am the common denominator. And, if I want to be professionally content, I better own every behavior, every decision, and every action that I bring to each patient and professional interaction.

For the past 8 years, I have had the privilege of serving on the Illinois Delegation to the APTA House of Delegates. If you have not had the opportunity to witness the House of Delegates, the governing body of the APTA, know that it is a group of 405 of the most comprehensive thinkers who have truly helped

me to see the many layers to each policy and position that we have adopted for the APTA over the years that I have served.

I would like to bring your attention to a few positions that we have crafted and perfected as a collective body, representing the whole association, as we challenge ourselves to debate over topics that we know will have a significant ripple effect. Each decision holds true for all practitioners, regardless of the practice setting. The motions passed in each house add to the definition of what it means to a member of the physical therapy profession.

One position that was adopted in 2010 and which impacts acute care practice settings significantly is RC 11-10.[2]

RC 11-10 Amend: standards of practice for physical therapy—physical therapist of record

> affirms that the physical therapist of record is responsible for patient/client management and is accountable for the coordination, continuation, and progression of the plan of care.

A position such as this impacts acute care practitioners most significantly I would argue, because of the frequency of care often being 3 to 10 times per week, and often the same practitioner does not see that patient every session because of the need for therapists to take comp days during the week to allow for weekend coverage and to limit the cost of overtime pay. In addition to those logistical issues, the acuity of any patient who is ill enough to require inpatient care is changing their needs and abilities at a high frequency, which requires that the plan of care and determination of disposition is often modified. These unique "isms" of acute care physical therapy require that there be a process not just for care to be given, but for adequate communication of all aspects of the physical, psychological, emotional, and sociological needs and abilities/resources be communicated within the compressed timeframe of an acute care inpatient stay. These responsibilities exist despite the other constraints of our day. The pace and complexity of acute care cannot distance us from our sense of our responsibility.

What else can distance us from our sense of ownership of our practice? Is it a sense of being beholden to the demands of our interprofessional colleagues, our patients, and our institutions that we feel that the decision is "out of our hands"? Truly, we, the hospital employees of the physical therapy department, are accountable to the interprofessional members of the health care team, our patients, and our employers, but we have to maintain the role of decision maker of the rate and intensity of exercise, the level of fall risk, the tools and methods used to maintain all activities within the patient's exercise tolerance, and every other important thing that we define in our patient examination, evaluation, and interventions. That decision should be made taking into consideration all of the vital information that we gain from our colleagues and patients, within our departmental constraints, not in spite of them.

Despite your best efforts, it is not always easy to own your decisions and actions, because there are situations where others presume that their foregone conclusion is the plan that all should follow, despite the fact that you have data to support your decisions and plan for the patient. Consider when a therapist is asked to see a patient so that the patient can be discharged. It may be that you uncover an issue, or 7 that make discharging unsafe. This is sometimes an uncomfortable situation that does not foster a collegial relationship, and sometimes can be a great opportunity to gain the respect and appreciation of your interprofessional colleagues as well as your patients. Being the practitioner of record requires that you put forth your most comprehensive effort to care for your patient and document the actions that you took to manage the situation.

The House of Delegates motion RC 27-07 further endorsed the position CORE VALUES.[3,4]

The core values of professionalism are accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. I will touch on the definitions of a few of the core values to speak to how ownership of your decisions and actions is not about deciding whether to incorporate as an LLC versus an S Corp, or determining what the most advantageous business structure is for your practice. It is about owning your every decision and action.

Accountability is active acceptance of the responsibility for the diverse roles, obligations, and actions of the physical therapist including self-regulation and other behaviors that positively influence patient/client outcomes, the profession, and the health needs of society.

In my heart of hearts, I believe that all practitioners are trying to meet this standard when they encounter their patients, but you always have to ask yourself whether you feel that you have the ability to remain true to this core value despite your employment relationship and regardless of reimbursement.

Excellence is physical therapist practice that consistently uses current knowledge and theory while understanding personal limits, integrates judgment and the patient/client perspective, embraces advancement, challenges mediocrity, and works toward development of new knowledge.

Integrity is steadfast adherence to high ethical principles or professional standards; truthfulness,

fairness, doing what you say you will do, and "speaking forth" about why you do and what you do.

I would highly recommend the tool, "Professionalism in Physical Therapy: Core Values Self Assessment" to appreciate the importance of these core values on your everyday practice.

And the last motion I will speak to came before the 2006 House, RC 13-06 Autonomous Physical Therapist Practice.[5]

Physical therapists are expected to practice autonomously in all settings, regardless of practice environment or business arrangement. Autonomous physical therapist practice is characterized by

- independent, self-determined professional judgment within one's scope of practice and in the patient's/client's best interest;
- responsibility and acceptance of risk for all aspects of the physical therapist patient/client management;
- ability to refer to and collaborate with health care providers and others to enhance physical therapist patient/client management;
- recognition of circumstances that necessitate a request for consultation and initiation of such consultation when in the best interest of the patient/client;
- incorporating the best available evidence within patient/client management;
- adherence to applicable legal and regulatory requirements.

Physical therapists and physical therapist assistants serve as part of interprofessional teams throughout the hospital. These teams facilitate shared responsibility, and research finding shows that this design best enhances a patient's safety and progression through the patient's plan of care. But does such team work also tend to subvert the physical therapist's or physical therapist assistant's ownership of her own decisions? Is autonomy the antithesis to functioning as a team, or is the team stronger when each component member can standalone?

How do you think a nurse or physician perceive your role if you ask, "Can I see Mrs Smith?" versus "I plan to see Mrs Smith, I saw that her K+ was low, did she already get her supplement? Did service already examine her after they saw that her Hgb dropped 2 grams?"

In the first scenario, the nurse or the physician may feel that you have given them the authority to determine the medical clearance for activity that you should have taken. No doubt, I greatly benefit from the input from my nurse and physician colleagues of the patient's upcoming medical interventions, test results, etc, but then it is up to me to determine how those may or may not impact their ability to participate in progressive mobility (eg, rolling repeatedly to walking in the hall). If the nurse is "in charge" of the determination of which activity was appropriate, what unique role do I as the PT serve? Most definitely, I confer with my nursing colleagues to determine whether my patients are optimized in their pain control, whether they have taken their BP meds, whether they are waiting to go to a vital medical imaging study or intervention, but I never ask them to determine what their exercise plan should be for my session.

Nurses' tasks and goals for the patient sometimes coincide with and sometimes conflict with the PT plan of care. Nurses are often expected to "get patients to the chair x number of times per day", if at all possible, but that should be designed to work with the other goals of the patient, versus an arbitrary number of tasks performed per day despite the patient's response.

I expect that my nurse colleagues are growing ever more aware of the need for mobility to manage comorbidities, but they benefit greatly from my input to decide how, when, and how much activity is appropriate. I expect that my nurse colleagues have a duty to reduce integumentary diagnoses as a result of hospitalization, to reduce days on the ventilator, to reduce CLABSI, CAUTI, and VAP. For my practicing acute care colleagues, you know that those stand for "central line-associated blood stream infection," "catheter-associated urinary tract infection," and "ventilator-acquired pneumonia." We all have a lot on our plates. My nurse colleagues have the greatest handle on the patient's plan of the day, and their input helps me to decide when the medical and social issues align appropriately to facilitate mobility, but they do not decide the course of the PT session.

As a result of the fast pace of acute care, a significant amount of vital information is acquired in a short period. As a practitioner perfects their skills, this process of information gathering and assimilation begins to look quite simple to the outside observer, though there is a complex amount of thought and analysis that is ongoing from the practitioner's perspective. Never diminish this. I repeat, never diminish this. The more that you understand and know the magnitude of your impact, the more you should want to own your practice. Use of pertinent scientific information to make clinical decisions impacts the financial, social, and emotional well-being of the patient. Their ability to resume their prior level of function, including physically, emotionally, socially, and economically might be largely impacted by the level of care that you offer your patient while they are your inpatient.

My students know that I design their cardiovascular physiology coursework at a high level and I make testing challenging because they will be responsible for patients. It is sometimes too abstract in the early months of their schooling to see the relationship between these 2 pieces. It does not help that there are many other, equally challenging, courses happening in the same trimester. But, when we speak to the fact

that they will sign their name to patients' records, that they will be the practitioner of record, and that they will determine disposition, which impacts so many layers of a person's life, it starts to soak in—sometimes to a point of fear rather than as an opportunity to help others.

As an educator, I know that my students will each see approximately 10 people per day when they begin practicing. The first-year class at Northwestern University has 96 students whom I taught cardiovascular physiology. If they do not gain sufficient knowledge of cardiovascular physiology, they will not be safe practitioners. Although I cannot take all of the blame or credit for their level of understanding, I know that if I do not teach them effectively, I could have a negative effect on upward of 960 people per day! I better own every lecture, every decision on what illustrative examples I include, and every action I perform in class to bring atherosclerotic vessels and dilated cardiomyopathies, among the many other diagnoses to life, so that their 960 patients per day will have a quality practitioner to help them.

When a practitioner determines fall risk, for example, in a patient who needs to be on anticoagulants to limit their risk of ischemic stroke, there are many factors to weigh into the decision. She needs to choose the most accurate measurement tool to best define the patient's fall risk. If the patient is inadvertently labeled as a patient at a risk of bleeding from a fall, they will not qualify for anticoagulation because of an inappropriately assumed high fall risk. Their risk of clotting then increases and the risk of having an ischemic event increases. Owning your practice means you know the impact of their medications, you used the most appropriate tool to gain an accurate measurement of their fall risk, you interpreted their social support and environment issues that can impact their risk, and you advocated for the appropriate level of care—not that you checked them off of your list.

The future of health care will require the redefinition of practitioners' roles and require that practitioners use a sound base that defines what their profession uniquely brings to serve the public, and to ensure that these roles maximize the strengths of each professional collectively contributing to the patient's care. We have a great challenge before us. We have to be sure to pave a path for ourselves, built by the stepping stones of our decisions and actions, so that we are able to traverse that path over and over again with sound footing.

I so appreciate that I was given this great honor, and I have so many people to thank for both supporting me and educating me to come to this point in my professional career. I have colleagues from various Illinois PT and PTA programs and IPTA who consistently share their expertise and constructive critiques that improve my teaching, my hands-on skills, and my role as a leader. I have a wonderful husband who understands my long work hours and that I gain so much from the many meetings that I attend and even then, I have a lot of association-related phone calls when I finally get home—all because I love being a physical therapist and am so thankful that I chose the right profession on the first try. All that I do for my profession makes me a happier Jenny, and he realizes that. I have 4-footed reminders that the laptop needs to go to sleep and a ball needs to be thrown for some balance. And, I have the exceptional insight that many patients have generously given me over the years. Everyday that I work, I strive to carry their wisdom forward to each new patient experience.

Thank you for your time and attention. Your dedication to the profession is recognized and appreciated.

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