Clinician's Commentary on Boyczuk et al.¹

Boyczuk and colleagues¹ present an interesting, multifaceted examination of the values applicable to or identified by practising physiotherapists and physiotherapy students in Canada. They describe their study as a first step in informing plans for future research, and they provide recommendations on the importance of values for educators, regulatory bodies, and professional associations.

The distinctions among beliefs, values, and behaviours may remain fuzzy despite all intelligent efforts to draw sharp lines. Neuroscientific and behavioural research do not bear out the notion that the distinctions are sharp or that people's behaviour is always determined by their stated values.² Moreover, there are constructs for which a person's thinking may go straight from belief to behaviour: for example, a person may believe that all people deserve respect, and a person's behaviour may show respect to people with whom that person interacts. What else to call the intervening value but *respect*? It may not reflect confusion about values and behaviours but rather an economy of language. In research on values, researchers should embrace the thinking that they are intricately connected with beliefs and behaviours.

Boyczuk and colleagues¹ make an interesting point, grounded in the literature, that core values may be less susceptible to change than other values. It may not be good use of curricular time to have university educators try to teach certain core values, such as altruism, compassion, and integrity. Many of them are embedded in *All I Really Need to Know I Learned in Kindergarten*,³ and they may be deeply ingrained in people who have arrived at university to become a health professional.⁴ Rather than designing education that views students' minds as blank slates or empty of core values, we should design education to guide students to operationalize their core values in their professional conduct. Educators can do this through explicit teaching or role modelling of how to interact with patients, co-workers, and others. These processes are part of the professional socialization that helps to form professional identity, as Boyczuk and colleagues describe.¹ For example, if we start from the premise that students entering physiotherapy education already place some value on compassion, we can guide them to reflect on how a practitioner's behaviour in a clinical scenario demonstrated compassion or to consider stories that prompt them to feel and reflect on compassion.⁵

Further research on values should consider combining survey methods with other methods. Even respondents to an anonymous survey can show social desirability bias, for example endorsing altruism because it feels immoral not to. Boyczuk and colleagues identified "patient/client centredness" as a value; this is a prevailing message in health care, and physiotherapists may want to think well of themselves for endorsing it without necessarily behaving in a fully patient-centred way. Using an auto-ethnographic method, Mudge and colleagues showed that, at least for two physiotherapists in New Zealand but also grounded in literature, some tensions in core beliefs may interfere with physiotherapists' ability to engage in person-centred practice.⁶ They noted a tendency to retain a paternalistic interaction with patients and a reluctance to engage in talking and listening because of the apparent value that physiotherapists hold of being action oriented.

Boyczuk and colleagues¹ proposed, on the basis of work done by others, that articulating values may promote unity and coherence in the profession. The profession should also examine its beliefs and their compatibility with physiotherapists' espoused values and societal contribution, and they should focus on relevance at least as much as on unity. For example, early codes of conduct for physiotherapists explicitly prohibited providing treatment to patients without medical referral.^{7,8} Physiotherapists' professional forebears were evidently united in believing in and valuing physicians' supervision and direction, in contrast to the profession's current unity about the value of autonomy and direct access.⁹ Physiotherapists who led this transition in values needed to be willing to challenge unity.¹⁰

Examining beliefs as well as values may help physiotherapists identify different things. Considering values may lead to a strong focus on morals and ethics – arguably shared by members of many other professions – whereas it may be easier to think of beliefs that are more strongly held by physiotherapists than by members of other professions. This wider lens may help us see what unites us and also what can impede us if it is not addressed. For example, Nicholls has argued that physiotherapists hold strongly to a belief system about the body as machine and that they must critically examine their strong beliefs in biomechanical explanations and solutions as paramount if physiotherapy is to remain a highly relevant profession for society.^{11,12}

Boyczuk and colleagues¹ have provided an important first step in articulating the values of physiotherapists in Canada. I join them in hoping that it fosters a national conversation and further research on this important topic.

Kathleen E. Norman, BScPT, PhD
Associate Professor and Associate Director, Research and
Post-Professional Programs, School of Rehabilitation
Therapy, Faculty of Health Sciences, Queen's University,
Kingston, Ontario; kathleen.norman@queensu.ca.

REFERENCES

1. Boyczuk AM, Deloyer JJ, Ferrigan KF, et al. Professional values: results from a scoping review and preliminary Canadian survey. *Physiother Can*. 2018;71(2):xxx-xx. <https://doi.org/10.3138/ptc.2017-70>.
2. Arieli D. *The honest truth about dishonesty*. London: HarperCollins; 2012.
3. Fulghum R. *All I really need to know I learned in kindergarten*. New York: Villard Books; 1988.
4. Collier R. Professionalism: can it be taught? *Can Med Assoc J*. 2012;184(11):1234–6. <https://doi.org/10.1503/cmaj.109-4232>. Medline:22761485
5. Chen P-J, Huang C-D, Yeh S-J. Impact of a narrative medicine programme on healthcare providers' empathy scores over time. *BMC Med Educ*. 2017;17:108. <https://doi.org/10.1186/s12909-017-0952-x>. Medline:28679379
6. Mudge S, Stretton C, Kayes N. Are physiotherapists comfortable with person-centred practice? An autoethnographic insight. *Disabil Rehabil*. 2014;36(6):457–63. <https://doi.org/10.3109/09638288.2013.797515>. Medline:23713969

7. Barclay J. In good hands: the history of the Chartered Society of Physiotherapy 1894–1994. Oxford, UK: Butterworth Heinemann; 1994.
  8. Linker B. The business of ethics: gender, medicine, and the professional codification of the American Physiotherapy Association, 1918–1935. *J Hist Med Allied Sci.* 2005;60(3):320–54. <https://doi.org/10.1093/jhmas/jri043>. Medline:15917259
  9. World Confederation for Physical Therapy. Policy statement: direct access and patient/client self-referral to physical therapy [Internet]. London: The Confederation; 2017 [cited 2018 Oct 10]. Available from: <https://www.wcpt.org/policy/ps-direct-access>.
  10. Kruger J. Patient referral and the physiotherapist: three decades later. *J Physiother.* 2010;56(4):217–18. [https://doi.org/10.1016/s1836-9553\(10\)70001-1](https://doi.org/10.1016/s1836-9553(10)70001-1). Medline:21091408
  11. Nicholls DA. The end of physiotherapy. Abingdon, UK: Routledge; 2018.
  12. Nicholls DA, Gibson BE. The body and physiotherapy. *Physiother Theory Pract.* 2010;26(8):497–509. <https://doi.org/10.3109/09593981003710316>. Medline:20795873
-
- DOI: [10.3138/ptc.2017-70-cc](https://doi.org/10.3138/ptc.2017-70-cc)