

Autonomy in Podiatric Practice

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Professional autonomy is an attribute that is broadly considered to contribute to the attainment of professional status. It is likely to be positively promoted by professional bodies and used as part of professional rhetoric to enhance university programme recruitment. Whilst some aspects of the notion of autonomy have informed studies mapping the professional development of podiatry, it is perhaps timely to explore the contemporary relevance of the concept for podiatry, particularly in light of the changing nature of current practice and career pathways.

Most podiatrists are familiar with the claim that their profession offers its members the opportunity of both independent and autonomous practice as well as the option of working within teams. Often the patient/practitioner relationship is considered to be unique and characterised by the autonomy of the practitioner in matters of diagnosis and management. However, failure to define autonomy adequately may give rise to a contradiction between claims grounded in professional rhetoric and those based on reality.

This paper attempts to revisit the theoretical basis of professional autonomy and seeks to develop a more applied definition that circumvents the misleading messages inherent in professional rhetoric and dogma, and enables a firmer appreciation of the relative uses of the concept of autonomy in a contemporary context. Of immediate relevance are the factors determining independent clinical decision making as distinct from the collective dynamics of professional power and authority. Thus, there are two key elements that when separated, offer potentially different insights into the role and authority of podiatrists, the power of the profession, and the authority of the individual practitioner.

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BACKGROUND

Notions of authority and autonomy have been used to help understand and classify the relative hierarchies evident in the professions, particularly the health professions.¹⁻⁵ Use of the term may, of course, reflect professional rhetoric, as a means to promote a particular image rather than necessarily describe a reality (Society of Chiropodists and Podiatrists - SCP). For example, descriptions of professions in vogue up until the 1960s, known as the 'trait' approaches, have long since been regarded as 'ideal typical constructions [that] do not tell us what a profession is, only what it pretends to be'.⁵

Definitions of 'professional autonomy' have certainly been used in such a way to promote the profession of podiatry.⁶ Autonomy may simply be considered to be independence and the freedom to exercise professional judgment within a given scope of practice⁷ and serve as the hallmark of professional status.⁸ However, such definitions are largely ahistorical and lack specific social context, as well as ignoring the underlying issues of professional power.

A full appreciation of these subtleties is provided in the sociological literature,⁹⁻¹² and the key links with professional power and authority identified.

Professionalisation, or the pursuit by professions of a 'professional project', designed to establish or enhance professional status, includes a focus on a number of related issues, such as educational achievement,⁹ client group status,¹² context and nature of work^{10,11} and external image to persuade different audiences.^{13,14} Moreover, establishment of 'specialised' higher level roles, or specialisms, within the professional scope of practice is also acknowledged as a component of professional status and a desirable attribute.¹² Professional status is not, however, achieved simply by accruing the attributes listed, but through a constant campaign to engage the support of 'powerful elites' that are able to endorse the achievements, and to combat competitors in an endless struggle to defend jurisdictions.^{1-3,11,15-17}

Professional autonomy is seen, in this context, as an outcome of this broader struggle, a signal of the success of the campaign, and one that must be guarded constantly and carefully. It is also used as a rhetorical device by professions to bolster claims to professionalism, as seen when deployed by the National Health Service (NHS)¹⁸ and the SCP media.⁶ A discourse of professionalism may thus be used by a profession to construct and maintain its occupational identity, promoting its image

to others.¹⁹⁻²¹ Here, the authors explore the concept of autonomy and seek to apply it within the contemporary context of the profession of podiatry.

PROFESSIONAL AUTONOMY: THEORY

Podiatry has been described as a unique profession that offers its members the opportunity of both independent and autonomous practice as well as the option of working within a team.²² It is the combination of such attributes that has been used to assert a significant distinction between podiatry and other healthcare groups, particularly those in the allied health professions. Is this merely professional rhetoric, or is there anything uniquely autonomous about podiatry?

Elston²³ provided a thoughtful exploration of the concept of autonomy in relation to professions, identifying three key forms: technical (clinical), economic and political. She did so in the context of an examination of a possible decline in medical power, in an era of neoliberalism. Further challenges to the authority of the health professions have been evident in recent years, from the public outcry over medical scandals to the growth in consumerism, where patients are increasingly urged to act as 'consumers' of services, to assert their rights and to exercise 'choice'.

Elston's typology, then, arguably assumes even greater relevance in the contemporary era. She draws a distinction between the authority that professions are able to exercise over other professions, and over their own ('dominance' and 'autonomy' respectively). Autonomy is taken to represent the 'legitimated control that an occupation exercises over the organisation and terms of its work', but is 'not an absolute property', thus acknowledging that no profession has ever really enjoyed complete or total autonomy. Key to the current debate is Elston's recognition of the distinction between autonomy as exercised by individual professionals (in a clinic or ward, for example), and by professions as corporate institutions, where it may be exercised at national or local level.

Economic autonomy reflects the power of the profession to determine its members' remuneration, to successfully influence the banding of pay or the funding of university places. Clearly, some professions are more successful than others are in this regard (a glance at medical and allied health professions pay scales will confirm it). Political autonomy - the 'right to make policy decisions as the legitimate experts' in their given field - also reflects the extent of the profession's

external control over its authority, and the extent to which it is regarded by other 'powerful elites' (such as the Department of Health or Government) or the public as the leading experts. Technical or clinical autonomy grants the power to determine clinical standards and performance, alongside the power to recruit, train and maintain control over professional behaviour (i.e. the authority of the professional body).

Turner^{24,25} suggested that exclusion, limitation and subordination are forms of medical dominance (authority exercised over the other health professions) that impact directly on the latter's professional autonomy. These three modes of control express the means by which medicine has been able to constrain and control the expansion and authority of the non-medical health professions. Thus, professions like dentistry, optometry and podiatry were limited to authority over a discrete area of the body, whereas acupuncture and homeopathy became excluded from mainstream healthcare, and nursing subordinated to direct medical control. Autonomy for these groups was necessarily curtailed as a result.

However, as neither dominance nor autonomy are absolute properties, or truly 'zero-sum' conflicts, exceptions may occur. Dominance in relation to autonomy has been explored theoretically by Mandy²² who compared podiatry to dentistry and discussed philosophically the 'act of practice' and the significance of positioning in reinforcing hierarchies of status. Earlier work by Borthwick *et al*²⁶ explored the importance and impact on professional developments in podiatry of the exercise of occupational imperialism and usurpatory social closure, concepts that it can be argued impact on autonomy in the non-medical professions. Thus, autonomy has been raised and debated within the podiatric literature, but largely confined to the use of the concept in relation to the corporate profession, and not the individual practitioner.

Broadly, professional autonomy may justifiably be regarded as a privilege that allows professions to exercise specific influence over, and to enjoy freedom within, their professional scope of practice. It is taken to reflect the specialised knowledge base of the profession (its skills and abilities), and it is the extent of its success in convincing others of the reality and legitimacy of these characteristics that enables a profession to be assigned status, social power and prestige.²²

In order to gain professional status it is therefore necessary for the profession and its members to be granted the freedom to

act autonomously. Constraints and obstacles to the attainment of this goal by the health professions are widely addressed in the literature. In particular, managerialism (demands made on the professions by managers seeking accountability, efficiency and demonstrable effectiveness) and consumerism (the trend for patients to be regarded as consumers purchasing a service, with consumer rights) feature prominently. Indeed, the post-professionalism literature foresees the emasculation of the professions, subject to informativity and external evaluation.

Nevertheless, the profession itself continues to value and seek prestige and professional status and, like all professions, continually engages in attempts to enhance and promote it. Borthwick *et al*²⁷ further found that podiatrists believed that a 'specialism' in practice enhances professional status, consistent with findings in the wider literature.¹⁴ Thus the development of 'specialised' techniques requiring the use of sophisticated technologies and knowledge within podiatry could therefore be construed as an attempt to enhance its status.¹⁴

This mirrors Hugman's¹² use of the conceptual notion of the 'virtuoso' role in allied health professions, in which the more glamorous and heroic acute care roles are associated more readily with high status, and, conversely, lower status linked to the more mundane activities of chronic long-term care, especially with low-status client groups, such as the elderly.¹² Within podiatry, virtuoso roles may include specialities such as musculoskeletal services or those carrying out tasks considered to be specialised tasks, for example nail surgery, foot surgery or biomechanics. Conversely, the more mundane tasks may include routine foot care (nail cutting and reduction of callus, i.e. provision of tasks that may be considered self-care).

Freidson¹⁻³ in his seminal works on the professions, proposed the notion of technical autonomy, which he defined as the 'right to use discretion and judgment in the performance of work'. Such behaviours are regulated increasingly by standards of practice, accreditation and licensure, all of which apply to the podiatry profession, and may be viewed as erosive to the exercise of clinical autonomy. Indeed, for some time the literature on the professions has been reconsidering the value of the long-standing concepts of 'deprofessionalisation' and 'proletarianisation' as explanatory constructs relevant to contemporary

professionalism.²⁸⁻³⁰ Central to these arguments is the loss of autonomy and control over work as a result of increasing managerial control and a much less deferential public acceptance of professional authority, as well as the gradual rationalisation of medical knowledge and an increasingly computer savvy public – captured in Muir Gray's description of the 'resourceful patient'.³¹

Professional autonomy is a common expectation as well as an aspiration for many professionals and professions^{32,33} both at corporate and individual level. However, in contemporary practice this may not always be the case, as challenges arise from managerial demands for accountability and performance measurement, service user demands, and national or local policy guidance and care management pathways. Thus, the importance and value of autonomy in contemporary practice may assume a greater significance to the beleaguered professional.

Podiatry is a profession that is marketed as an autonomous profession, a positive attribute that may make it particularly attractive and possibly distinct from other professional disciplines, at least in terms of the single practitioner practice, where the clinician works entirely alone, with decision-making authority to treat or refer (albeit within certain limits). This notion of self-governance is seeded from commencement of training and may be considered fundamental to the podiatrists' scope of practice – it is clearly central to the concept of autonomy. Professional autonomy in podiatry permits the professional particular independence and freedom of decision making and reasoning in the context of clinical and professional practice. However, philosophically, whilst podiatrists may enjoy a high degree of clinical autonomy, overall professional autonomy (economic, political, and technical) may be compromised by the external societal envelope, or professional environment, in which they practice. The professional environment may impact on the clinical autonomy and undermine the overall professional autonomy.

WHO'S AUTONOMY? THE PATIENT AND PRACTITIONER DICHOTOMY

If the definition of autonomy, as related to independence,³⁴ is adopted without question, then there may be a conflict rather than congruence between the practitioner's need for autonomy and patient need for autonomy. Any definition proposed must take account of the need to consider autonomy as relational, in that everyone within the professional



relationship (including the patient) has a right (and an expectation) to be autonomous, which must be balanced with the rights of others within the relationship.

Wade³⁵ discussed professional autonomy and linked it to the centrality of the client (patient) in the decision-making process. This interpretation, however, has limited application to podiatric practice because the impact of the professional environment or workload on the practitioners' ability to practice autonomously is not overtly considered. Keenan³⁶ also discussed the patients' right to be autonomous but does not discuss the potential for patients' autonomy to conflict with the practitioners' autonomy. Whilst Keenan³⁶ defines autonomy as 'the exercise of considered, independent judgement to effect a desirable outcome', it is arguably no longer applicable to the patient-podiatrist relationship, as decisions in contemporary practice are not made independently but in partnership. However, within this partnership, as discussed, both parties have the expectation and desire to be autonomous. Lupton³⁸ concludes that, whilst the nature and balance of doctor-patient interaction has changed from "dependent patient discourse" to 'the consumerist discourse', this does not necessarily involve a loss of professional status or autonomy. However, the representation of the patient as the reflexive, autonomous consumer often fails to recognise the often unconscious, unarticulated dependence that patients may have on doctors.³⁸



Conversely, Fairclough³⁹ has also argued that the doctor-patient relationship has shifted from a 'medical discourse' into the 'counselling discourse', which has contributed to a reduction of power asymmetries. Policy initiatives certainly reflect these cultural shifts, stressing the greater need for patient empowerment, involvement and choice (such as Department of Health partnerships).

Ovretveit³⁷ offers a detailed and cogent analysis of the subtle facets of autonomy, and acknowledges the challenges it poses for the physiotherapy profession. For him, two distinct types of autonomy are relevant; 'case autonomy' and 'practice autonomy'. Both types focus on the freedom of the practitioner to exercise discretion in carrying out the therapeutic role. Case autonomy centres on the freedom to manage patient treatment interventions, whilst practice autonomy focuses on the management of a department or speciality.

While these definitions still do not entirely capture the independence of the sole practitioner responsible for managing a caseload in addition to undertaking the management of a single clinic, Ovretveit offers a far more sensitive and nuanced analytic tool. The inherent incongruity and contradiction in interests between professions and patients (or clients) is acknowledged more fully by Bourgeault, Hirschhorn & Sainsaulieu,⁴⁰ who draw attention to the need for more in-depth analyses.

Furthermore, growing demands for

professional accountability continue to stress the importance of evidence-based practice in justifying claims for professionalism.⁴¹ Richardson⁴¹ suggests that, where a profession cannot provide evidence for its interventions or practices, then its autonomy may be reduced. This is certainly applicable to podiatric practice where the evidence base is still in its relative infancy.^{42,43}

Thus, central to any meaningful and contemporary concept of podiatric autonomy is an acknowledgement of the complexity of both inter-professional and practitioner-patient relationships.

REVISITING AUTONOMY: RELEVANCE FOR PODIATRY

It is suggested that a meaningful definition of autonomy, of relevance within a contemporary healthcare context, should acknowledge both the clinical and non-clinical elements of practice. A nuanced consideration of the complex relationships that may impact on freedom/control within these clinical/non-clinical elements is also required, in the context of a post-professional world.^{44,45}

It is therefore proposed that podiatric autonomy may usefully be considered to consist of two key elements that include both a professional and clinical dimension, mirroring Ovretveit's model.³⁷ The professional dimension reflects the extent of an individual's control over the external factors that contribute to their professional work.

This includes scheduling of work, work environment and work-related non-clinical tasks. The clinical dimension relates to the individual practitioner's freedom to make clinical decisions in order to achieve the best possible clinical outcome. Such a definition would encapsulate every aspect of the podiatrist's role. It is, arguably, meaningful to consider a distinction between the two, as each may be influenced by opposing forces; managerialist and consumerist agendas.

Within each of these dimensions of autonomy, different relationships must be explored, on which and from which one's autonomy can be enhanced or restricted. For example, podiatrists may find their professional autonomy restricted by a line manager, organisational constraints or team members. Equally, the patient is increasingly the person most likely to impact or restrict the podiatrist's clinical autonomy. An example of this may be a patient challenging decisions made by the podiatrist.

Such a view of autonomy is relational and acknowledges the importance and significance of self-direction, whilst also

being underpinned by relationships with patients and colleagues in the workplace. The workplace also becomes instrumental in the support of such relational autonomy by permitting staff to exercise judgement (Elston's 'local level' arrangements²³). Acceptance of this relational element to the clinical and professional variants of autonomy may add a new contemporary dimension to the concept of autonomy in podiatric practice. It is also important to note that much research to date is based on NHS podiatrists and, as such, the application of such definitions to private practice warrants further exploration.

In addition, it is proposed that the exercise of autonomy in its nuanced forms is dynamic and temporally bound, varying at different stages across a career. It is likely, we would argue, that the extent of clinical autonomy and professional autonomy sought by each individual will vary, with some practitioners desiring more professional autonomy than others, with this desire often increasing as the podiatrist becomes more experienced.

CONCLUSION

It is important to review conceptions of autonomy contemporaneously and to situate them in the context of the changing nature of practice.

Expectations of autonomy must therefore be considered in the context of colleagues and patients at a micro level, as much as policy and culture change at macro level. It is clear that the challenge to professionalism and professionalising ambitions is growing in an environment requiring increasing professional accountability, fiscal constraint, transparency and openness, alongside the rationalisation of, and broader access to, professional knowledge and a growth in patient empowerment.

More traditional interpretations of autonomy, as related to independence, may not always prove fruitful in a contemporary context, in which varied and complex interactions and realigned power relationships now predominate. Failure to realise this reality and to accept the inevitable adjustments may lead to dissatisfaction in the workplace, and, as previous research has suggested, may lead to occupational stress.⁴⁶

Authors' contribution:

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