

FLEX CEUs



Ethics & Jurisprudence for the Wisconsin Physical Therapist



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OUTLINE

Course Outline	1
Introduction	2
Instructor Biography	2
Importance of Ethics	2
Ethical Dilemmas	3
Ethical Approaches	4
Ethics Versus Morals	5
Bioethical Concerns	7
HIPAA	7
Licensure and Regulation	7
State Licensure and Regulation	7
Purpose and Requirements for State Licensure	8
State Regulatory Boards	10
Wisconsin Regulations	11
APTA Code of Ethics	29
APTA Guide for Professional Conduct	35
Respect	35
Altruism	35
Patient Autonomy	35
Professional Judgment	36
Supervision	37
Integrity in Relationships	37
Reporting	37
Exploitation	38
Colleague Impairment	38
Professional Competence	39
Professional Growth	39
Charges and Coding	40
Pro Bono Services	40
Case Examples	41
References	42

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Introduction

This course fulfills the 4-hour continuing competency requirements for ethics, laws, and regulations for physical therapists practicing in the state of Wisconsin. The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA). Regulations pursuant to the state of Wisconsin will also be reviewed.

Instructor Biography

Michele S. Jang, PT is a course author for Flex Therapist CEUs; providing online continuing education units for physical therapists. She graduated with a degree in physical therapy from California State University, Long Beach. She is an experienced educator and currently manages a private physical therapy practice.

Importance of Ethics

Ethics is defined as "that branch of philosophy dealing with values relating to human conduct, with respect to the rightness and wrongness of certain actions and to the goodness and badness of the motives and ends of such action" (Ethics, 2014). Ethics define what governs our value system and steers our moral compass in any given society or culture. Since the dawn of civilization, societies have had to come to an agreement on what standards they would hold their citizens accountable to; whether that is sanctioned by an aristocracy, religious instruction, or system of government. We can find the beginnings of ethics in the study of the earliest nomadic people and cooperative groups who sought to not only live for today's survival, but also held a vision to building a future, using standards that were agreed upon. The concept of marking time, calendars, and agriculture depended on the cooperation of people working in harmony with one another and following the same guidelines. The Code of the Hammurabi was the earliest Sumerian code of ethics and laws to be written down for the sake of establishing a standard of morals and consequences. This is where the popular "eye for an eye" concept came from (Hammurabi, 2014). In medicine, there is another defining code of ethics, coined by Hippocrates as the Hippocratic Oath. This is where ethics in medicine begins and is the cornerstone to a physical therapy practice. Though times have changed, the importance of "do no harm" is emphasized.

The Oath

By Hippocrates

Written 400 B.C.E

Translated by Francis Adams

I SWEAR by Apollo the physician, and Aesculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation- to reckon him who

taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath un-violated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!

Ethical Dilemmas

Ethical dilemmas are issues and situations that cause friction against the primary code of ethics physical therapists are required to follow. While most physical therapists would consider themselves highly ethical and may have a hard time imagining themselves acting immorally, an ethical dilemma may emerge from something as innocent as conflicting state and county guidelines or unknowingly using outdated standards or therapeutic equipment. Physical therapy works specifically in the care and well being of humans. As such, maintaining and keeping healthy and professional boundaries and clear communication are integral to the healthcare field. “Do No Harm” is not a term to throw around lightly, but to hold us firm in our convictions to provide the best possible care, while weighing out carefully all the possible side effects or consequences of our actions, however far reaching. Let’s take a look at a scenario which brings up an ethical dilemma and ask the ethical question of, “What is the right thing to do?”

Scenario: It is the end of a long day of treating clients and you have just completed your note on your last patient, Mrs. Jones. Mrs. Jones has difficulty walking and is at high risk for falls. She has limited use of her arm as well as some short-term memory loss. She relies on friends and family to provide transportation. Her daughter has been running errands and will be picking Mrs. Jones up but you notice that the daughter has not come

yet. You have front row concert seats and are meeting a friend in 15 minutes. No one else is in the office and as it stands, you need to lock up. You search for the daughter's phone number but can't find it, and Mrs. Jones is unable to recall the number herself. What do you do? Do you: A) sit with Mrs. Jones in the office and wait until the daughter arrives, or B) have Mrs. Jones wait outside the office in the parking lot?

"*What is the right thing to do?*" While it is human nature for us to want to satisfy our own desires, it is our ethical responsibility to put the needs of the clients first. As much as you may have wanted to attend the concert and as much as the seats may have cost, there is no comparison in price that matches another person's life, well-being, and safety.

Ethical Approaches

There are different schools of thought which utilize ethics to make decisions. We will explore five of these.

Utilitarianism:

"Actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness" – John Stuart Mill

Utilitarianism is the ethical approach that promotes the maximum of pleasure and happiness with the minimum of pain and suffering. This sounds pretty reasonable and most people would tend to agree that given a choice between pleasure and pain, most people are going to go with pleasure. Utilitarianism takes this approach a step further in not only seeking benefits of pleasure for oneself, but making decisions that will give the most people benefits, while inflicting suffering as little as absolutely possible (Driver, 2014).

Personalized:

This relatively recent take on ethical responsibility has been brought to light due to medical advances and the ability to personalize a client's profile in order to concentrate their treatment or tailor their prescription. Modern science has even mapped the human genome through Whole Genome Sequencing. The original intention is to reduce the amount of mortality and morbidity due to faulty diagnosis or prescription from an adverse drug response. But how much information is too much information? Where does the "right to know" boundary lie? What if we knew an unborn fetus has a grave disorder? What if a new drug was known to treat this disorder but in doing so put the pregnant mother at risk? (Vogenberg, 2018)

Deontologic:

According to the Encyclopedia Britannica, the philosophy of Deontology is derived from the Greek deon, "duty," and logos, "science," focusing on logic and ethics. Deontological thought comes from the place that there is definitely a

“right” and a “wrong” and that humans should strive to always do the right thing, regardless of the cost ("Deontological ethics," 2014).

Ethical Intuitionism:

Ethical intuitionism relies heavily on our intuitive sense or ‘common sense’ to guide our moral compass. It supposes that there are certain inherent truths that we can discern without having facts or a formal education on the subject. We don’t need a religious teaching or edict from the Queen to tell us that taking care of our young is a good thing or that kicking animals is a bad thing. Sadly, this doesn’t mean that everyone is on the same page with these inherent truths, which is where the law of Karma comes in (Stratton-Lake, 2014).

Natural Law Theory:

Natural Law is one of those rare ethics philosophies that both theists and atheists can actually agree on. This law speaks to our common sense approach to basic survival, basic goodness, and basic decency as human beings. It states, “The atheist uses reason to discover the laws governing natural events and applies them to thinking about human action. Actions in accord with such natural law are morally correct. Those that go against such natural laws are morally wrong. For the theists there is a deity that created all of nature and created the laws as well and so obedience to those laws and the supplement to those laws provided by the deity is the morally correct thing to do” (Murray, 2014).

Ethics Versus Morals

While these terms are often used interchangeably, there is a difference between ethics and morals. Morals generally refer to what an individual considers “right” and “wrong” or wrong, whereas ethics are rules that are generally agreed upon by a group of people, such as a workplace, or society at large. (“Ethics vs”, 2018) Shared morals may help guide ethical policies, and in turn ethics may help guide morals. However, this distinction is important to make as situations may occur in which a physical therapist’s personal morals do not perfectly align with a code of ethics.

Morality is defined as: “conformity to the rules of right conduct; moral or virtuous conduct” ("Morality," 2014). Morals can be virtuous, but they stem from a cultural, religious, or belief system context, that can change and evolve.

As part of determining a code of ethics that protects and benefits all people, we take bits and pieces of what has worked for thousands of years, what is deemed “true” and “virtuous” and what is in the best interest of our community. Let’s take a look at some more of these contributing thoughts that make up the whole.

Altruism: Altruism is the practice of acting towards the benefit of another without any regard to benefit for yourself.

Dignity: All people have the right to their own dignity or “worthiness.” They have the right to be treated with respect regardless of background, income level, ability, gender, age, or any other factor that uses a hierarchical pecking order. When all else fails, stick with the golden rule, “Treat others as you would want to be treated.”

Equality: Equality is a leveling of the playing field. In cases of economic parity and great need for healthcare, equality and justice both serve the community by saying that everyone deserves equal access to healthcare.

Freedom: Freedom in the framework of ethics says that a person has the freedom of their own autonomy, up to, but not including the freedom to affect another person negatively. A scenario which describes this term is the following: A person has a right to choose to smoke tobacco, but they do not have the freedom to make that health choice for other people via second hand smoke. Therefore we have laws which limit the areas in which to smoke.

Prudence: Caution and discretion in practical manners.

We now have a basic knowledge of some of the foundations of ethical reasoning and how morals can be brought into play. However, what are values and how do they fit in? Values are a way to quantify the worthiness of the principles and morals a group holds dear. “Family Values” encompasses many characteristics that would be thought as the most beneficial way to raise and care for a family. In the same way, ethical values are the pathway that the healthcare field utilizes as their foundation for the success of their patients, colleagues, employees, and research participants.

Values are of great benefit to:

- clients who know their rights and choices will be respected and that they will be treated with dignity as a partner in their path to well being
- employees who know what is expected of them and have the comfort and empowerment of recourse and redress if an issue or concern comes up
- colleagues who will be treated with professional respect for their knowledge and expertise that they bring
- research participants who are empowered by their contribution and autonomy to choose to participate
- the PT, who knows their tradition is from a long line of tried and proven methods that benefit and serve their community with dignity

While we looked at all of the values, the virtues, and the morals of operating within an ethical model, the bottom line is: following the Code of Ethics keeps your patients safe and your business secure. Operating within ethical standards not only ensures that you are serving your patients to the best of your ability, it protects your license and therefore,

your livelihood. While you may encounter local, cultural, and practical variations, the standards within the Code of Ethics are recognized throughout the world, and becoming familiar with them will provide knowledge you will use for the rest of your practice.

Bioethical Concerns

Bioethical concerns relate to how we approach newer technologies ethically. Examples include: Artificial insemination, cloning, stem cell research, and prolonging care for those in long-term comas. These are not “naturally” occurring for humans, but instead is the result of human engineering. There is great debate among cultures and religious groups who have moral objections to invasive procedures.

HIPAA

HIPAA is the federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of healthcare information, and help the healthcare industry control administrative costs (HIPAA, 2017).

Licensure and Regulation

As members of a health care profession, and similar to other health care professions, physical therapists in the United States are licensed and regulated by individual states. This information reviews the licensure status of physical therapists in all states and the District of Columbia, describes the purpose and requirements of state licensure, outlines licensing board structure, and provides information about terms and titles. Other than the information specifically about licensure of the physical therapist, the following information also applies to the physical therapist assistant. Information specific to physical therapist assistant licensure/regulation can be found in the section on physical therapist assistants.

State Licensure and Regulation

Physical therapists are licensed in all 50 states and the District of Columbia. State licensure is required in each state in which a physical therapist practices and must be renewed on a regular basis, with a majority of states requiring continuing education or some other continuing competency requirement for renewal. A physical therapist must practice within the scope of physical therapy practice defined by his or her state law governing the licensure and practice of physical therapy (often referred to as the “practice act”).

Purpose and Requirements for State Licensure

State licensure is inherently restrictive for the licensee and exclusive to the particular

profession. Only those who “meet and maintain prescribed standards” established by the State’s regulatory board will, for the protection and benefit of the public, be allowed to profess their qualifications and provide their services to the public. The public is dependent upon the State to evaluate and affirm the qualifications for licensure of physical therapists. One of the main tools used by a State’s regulatory entity to determine if a physical therapist has met that threshold is the physical therapist’s passage of the National Physical Therapy Exam (NPTE) of the Federation of State Boards of Physical Therapy (FSBPT). The NPTE is the only examination for licensure of physical therapists—all 50 states and the District of Columbia use it. The NPTE is “competency specific” and covers the entire scope of entry-level practice, including theory, examination and evaluation, diagnosis, prognosis, treatment intervention, prevention, and consultation that are consistent with the exam blueprint. A formal, systematic process referred to as an “analysis of practice” determines the contents of a licensure examination. This process begins with the identification of work requirements for entry-level practitioners and ends with the development of a formal set of test specifications that delineates the knowledge and skills related to safe and effective entry-level practice.

Because physical therapy practice evolves, it is imperative that the licensure examinations be updated on an ongoing basis. Thus, a practice analysis must be conducted periodically to ensure that changes in entry-level requirements are incorporated into the licensure examinations. Revisiting the practice analysis regularly ensures that fewer test questions are included on skill areas of decreasing importance and more test questions address skill areas of increasing importance. The time frame for updating a practice analysis varies by profession; for the physical therapy profession this analysis is conducted at least every 5 years.

Another important qualification for licensure is graduation from an accredited physical therapy education program or a program that is deemed substantially equivalent. The Commission on Accreditation of Physical Therapy Education (CAPTE), recognized by the United States Department of Education as the specialized accrediting agency for physical therapy education programs, sets the quality threshold standards that physical therapist programs must meet in order to be accredited.

State Regulatory Boards

Most jurisdictions have independent state boards of physical therapy, but some jurisdictions’ physical therapy boards are part of state medical boards or combined with other professions. There are also a few “super boards,” under which all regulatory activities are subordinate to one board, with distinct committees or commissions for the various professions. Independent licensing boards are preferred because they provide the necessary expertise specifically for regulation of physical therapy practice. Most jurisdictions have licensing board members who are appointed by an elected official, usually the governor. Often they include 1 to 2 public members. Smaller jurisdictions may have fewer than 5 total board members, while larger ones have far greater numbers. When a state’s practice act is silent on an issue or intervention, the determination of what constitutes practice “beyond the scope” of physical therapy is predominantly the

responsibility of licensing board members. Scope of practice changes as contemporary practice evolves, and boards need the latitude to determine the appropriateness of physical therapy procedures as they relate to both established and evolving scope of practice.

The Model Practice Act for Physical Therapy

Over decades, the various physical therapy practice acts have contained functional and useful regulatory language but also some problematic language. Most jurisdictional practice acts had their origins in the 1950s and early 1960s, and amendments turned some practice acts into cobbled-together collections of regulatory language that are very diverse in their approach to the basic board responsibility of protecting the public and regulating the profession. FSBPT created *The Model Practice Act for Physical Therapy: A Tool for Public Protection and Legislative Change (MPA)* in 1997 as the preferred tool for revising and modernizing physical therapy practice acts. FSBPT encourages jurisdictions to review, improve, and strengthen practice acts, using the latest edition of the MPA as a resource. The continuing movement to update physical therapy practice acts helps ensure that they provide the legal authority to fully protect the public while effectively regulating the profession. The FSBPT task force that began developing the MPA in 1994 originally envisioned a model act that could be used cafeteria style to allow states to change a specific section of a practice act as needed. While the MPA can be used effectively in this manner, it also is a tightly constructed and integrated model for the regulation of physical therapy. The sections of the MPA complement each other—certain areas of the MPA are indispensable from others, and changes in one area might require modification of a state’s practice act in other areas. The commentary sections of the MPA identify important cross-links in statute language. Since 1997 many states have enacted large portions of and, in some instances, nearly the entire Model Practice Act as their state statute.

Terms and Titles of the Physical Therapy Profession

State regulation restricts how licensees represent themselves, including their use of titles and/or letters, so that they do not mislead the public. For example, a medical or osteopathic physician practices and represents to the public that he or she practices medicine but not dentistry. When practitioners other than physical therapists represent that they are providing “physical therapy” or “physiotherapy,” they are violating the very spirit and core of licensure law by misrepresenting themselves to the public. A claim that “physical therapy” or “physiotherapy” is a generic term is misleading to the public. The protection of these terms is not referring to protection against the use of various physical agents, modalities, or procedures by others, but rather is against the inappropriate labeling of those modalities and procedures as physical therapy. In addition the title “PT” is the professional and regulatory designation that practice acts require physical therapists (and no others) in the United States to use to denote licensure. The use of the initials “DPT” by physical therapists indicates that they have obtained a doctoral degree in physical therapy (DPT). Use of the initials “DPT” should be used in conjunction with the licensure designation of “PT.”

Direct Access to Physical Therapist Services

The vast majority of U.S. jurisdictions have some form of patient access to evaluation and treatment by licensed physical therapists. Access to physical therapist services is critical to ensuring optimum patient functional status and independence. Throughout the experience of obtaining direct access at the state level, physical therapists have been questioned about their ability to identify a patient's signs and symptoms correctly, especially those that may represent cancer or other life-threatening conditions, if the patient has not first been screened by a physician. The misguided presumption is that physical therapists are not sufficiently educated or clinically trained to correctly diagnose an underlying pathological condition. This argument falsely concludes that direct access to physical therapists is therefore a threat to the safety of the public. However, a closer look at the facts and evidence proves otherwise.

Physical therapists diagnose impairments, functional limitations, and disabilities related to medical conditions, movement dysfunction, and other health-related disorders. Physical therapists do not provide a medical diagnosis. However, they are well-prepared to identify when a patient's signs and symptoms potentially lie outside the scope of the physical therapist's diagnosis and require a referral to a physician for further diagnostic work-up and identification of underlying pathology. The examination process, routinely employed by physical therapists, ensures that direct access to physical therapists also allows referral to physicians when indicated. With more than 30 years of experience with direct access in the states that permit it, physical therapists have not been noted to misinterpret a patient's signs and symptoms as non-pathological leading to serious injury or death. Physical therapist malpractice rates do not differ between states with patient direct access and those with a physician referral requirement. Furthermore, when the number of complaints filed against physical therapists with state licensure boards were examined prior to and after elimination of the physician referral requirement, no increase of complaints centered on patient harm was found. In a study from 2017 entitled "The Influence of Patient Choice of First Provider on Costs and Outcomes: Analysis From a Physical Therapy Patient Registry," outcomes from direct access care and physician referral were compared. No difference in care or outcomes were found, and additionally the direct access group was noted to spend \$1,543 less on average on total treatment costs, indicating that direct access is equally as safe and potentially more cost-efficient. (Denninger, 2017). Most referrals from physicians are written as "evaluate and treat." Medical "diagnoses" may be non-specific terms such as "low back pain." Even if a specific medical diagnosis is provided along with an "evaluate and treat" referral, it is incumbent upon the physical therapist to identify the rehabilitation diagnosis. Physical therapists independently design the plan of care and the schedule of implementation. It is the physical therapist who has ultimate responsibility for what interventions will be provided, how many times a week or month the patient will be seen, and the overall duration of the episode of care. Direct access also supports a collaborative model of practice between physicians and physical therapists and can create opportunities that enhance patient management, safety, and outcomes. Collaboration is, in many respects, the flip side of the direct access "coin." Historically, physical therapists emerged as a profession within the medical model, not as an alternative to medical care. Traditionally,

physical therapists receive a substantial proportion of their clinical education and training in academic medical centers and hospitals, where team collaboration is paramount. Both physical therapists and physicians have a mutual respect for, and deep understanding of, their complementary roles in patient care. Direct access does not alter that relationship; it merely allows the collaboration to be initiated by the physical therapist at a point in the physical therapy episode of care that is most beneficial to the patient and most cost effective for the health care system.

Wisconsin Regulations

LICENSE TO PRACTICE PHYSICAL THERAPY

PT 1.01 **Authority and purpose.**

(1) The rules in this chapter are adopted by the physical therapy examining board pursuant to the authority delegated by ss. 15.08 (5) (b), and 15.405 (7r), 448.53 (1), Stats.

(2) The rules in this chapter are adopted to govern the issuance of licenses to physical therapists and physical therapist assistants under ss. 448.53, 448.535, 448.54, and 448.55, Stats. History: Cr. Register, September, 1995, No. 477, eff. 10-1-95; am., Register, June, 1998, No. 510, eff. 7-1-98; CR 03-020: am. Register April 2004 No. 580, eff. 5-1-04; CR 12-002: r. and recr. Register August 2012 No. 680, eff. 9-1-12.

PT 1.02 Definitions. As used in chs. PT 1 to 9:

(1) “Board” means the physical therapy examining board.

(3) “Client” means a person who has contracted for, who receives, and or who has previously received or contracted for, the professional services of a physical therapist, a physical therapist assistant, student or temporary licensee, whether the physical therapist, student or temporary licensee is paid or unpaid for the service, and regardless of where such services occur. If a client is a person under age 18, the client’s parent or legal guardian are also clients.

(4) “Direct, immediate, on-premises supervision” means face-to-face contact between the supervisor and the person being supervised, as necessary, with the supervisor physically present in the same building when the service is performed by the person being supervised.

(5) “Direct, immediate, one-to-one supervision” means one-to-one supervision with face-to-face contact between the person being supervised and the supervisor. The supervisor may assist the person being supervised as necessary.

(6) “FSBPT” means the Federation of State Boards of Physical Therapy.

(7) “General supervision” means direct, on-premises contact between a supervisor, and a physical therapist, physical therapist assistant, student or temporary licensee being supervised, as necessary. Between direct contacts, a supervisor is required to maintain indirect, off-premises telecommunication contact such that the person being supervised can, within 24 hours, establish direct telecommunication with a supervisor.

(8) “Informed consent” means a client’s voluntary, knowing and understood agreement to the service to be provided by the physical therapist, physical therapist assistant,

temporary licensee, candidate for reentry, or student. Informed consent requires, at a minimum, that the licensee has provided information about reasonable alternate modes of diagnosis and treatment, and the risks and benefits of each, that a reasonable person in the client's position would need before making an informed decision concerning the mode of treatment or diagnosis.

(a) Informed consent may ordinarily be documented by the written signature of the client, the client's guardian or the client's power of attorney for healthcare, or in the alternative by a notation in the patient's health care record as defined in s. 146.81 (4), Stats. If circumstances prevent signed documentation by the client, the licensee may document verbal consent within the patient's health care record.

(b) A client may withdraw informed consent verbally or in writing at any time before a service is completed.

(c) Informed consent shall include an understanding that the client may, upon request, have a chaperone present while services are provided.

(d) No service or part of a service may be provided without the client's informed consent or after informed consent has been withdrawn.

(e) No service or part of a service may be provided without informing the client of the general nature of the costs associated with the service provided or contact information for the entity who can address billing concerns.

(9) "Intimate parts" has the meaning given in s. 939.22 (19), Stats.

(10) "License" means any license, permit, certificate or registration issued by the board.

(11) "Licensee" means any person validly possessing any license granted and issued to that person by the board.

(12) "Supervisor" means a person holding a regular license as a physical therapist who is competent to coordinate, direct, and inspect the accomplishments of another physical therapist, physical therapist assistant, student, or temporary licensee.

(13) "Temporary licensee" means a graduate of a physical therapy school or program who has met the requirements for and who has been granted a temporary license to practice as a physical therapist or physical therapist assistant as provided in ch. PT 3.

(14) "Unlicensed personnel" means a person other than a physical therapist or physical therapist assistant who performs patient related tasks consistent with the unlicensed personnel's education, training and expertise under the direct on-premises supervision of the physical therapist.

History: *Cr. Register, September, 1995, No. 477, eff. 10-1-95; r. (5), cr. (6), Register, April, 2000, No. 532, eff. 5-1-00; CR 03-020: am. (intro.), (2) and (6) Register April 2004 No. 580, eff. 5-1-04; CR 12-002: am. (1), renum. (2), (3), (4) to be (6), (10), (11), cr. (2) to (5), renum. (6) to be (14), cr. (7) to (9), (12), (13) Register August 2012 No. 680, eff. 9-1-12; CR 15-027: r. (2) Register January 2016 No. 721, eff. 2-1-16.*

PT 1.03 Licensure requirements.

(1) Every person applying for any class of license to provide physical therapy services shall submit to the board all of the following:

(a) A completed and verified application form provided by the board and the fees specified in s. 440.05 (1), Stats.

Note: Application forms are available upon request to the board office at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708.

(c) For a physical therapist, verified documentary evidence of graduation from a school of physical therapy; for a physical therapist assistant, verified documentary evidence of satisfactory completion of a physical therapist assistant educational program approved by the board.

(d) In the case of a graduate of a foreign school of physical therapy or physical therapist assistant educational program, verification of educational equivalency to a board–approved school of physical therapy or physical therapist assistant educational program, the verification shall be obtained from a board–approved foreign graduate evaluation service, based upon submission to the evaluation service of the following material:

1. A verified copy of transcripts from the schools from which secondary education was obtained.
2. A verified copy of the diploma from the school or educational program at which professional physical therapy or physical therapist assistant training was completed.
3. A record of the number of class hours spent in each subject, for both pre-professional and professional courses. For subjects which include laboratory and discussion sections, the hours must be described in hours per lecture, hours per laboratory and hours per discussion per week. Information must include whether subjects have been taken at basic entry or advanced levels.
4. A syllabus which describes the material covered in each subject completed.

(e) Evidence of successful completion of the examinations specified in ch. PT 2.

(2) If an applicant is a graduate of a school of physical therapy or a physical therapist assistant educational program not approved by the board, the board shall determine whether the applicant’s educational training is equivalent to that specified in sub. (1) (c). In lieu of its own evaluations, the board may use evaluations prepared by a board–approved evaluation service. The cost of an evaluation shall be paid by the applicant.

Note: The board periodically reviews and approves foreign graduate evaluation services. A list of board–approved evaluation services is available upon request from the board at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708–8935.

(3) The board may waive the requirement under sub. (1) (c) for an applicant who establishes, to the satisfaction of the board, all of the following:

- (a) That he or she is a graduate of a physical therapy school or a physical therapist assistant educational program.
- (b) That he or she is licensed as a physical therapist or physical therapist assistant by another licensing jurisdiction in the United States.
- (c) That the jurisdiction in which he or she is licensed required the licensee to be a graduate of a school or educational program approved by the licensing jurisdiction or of a school or educational program that the licensing jurisdiction evaluated for educational equivalency.
- (d) That he or she has actively practiced as a physical therapist or physical therapist assistant, under the license issued by the other licensing jurisdiction in the United States, for at least 3 years immediately preceding the date of his or her application.

Note: The board approves those schools of physical therapy and physical therapist assistant educational programs that are at the time of the applicant’s graduation

recognized and approved by the Commission on Accreditation in Physical Therapy Education.

Note: Under 2001 Wis. Act 70, physical therapist assistants are not required to be licensed until April 1, 2004.

History: *Cr. Register, September, 1995, No. 477, eff. 10-1-95; r. (1) (b), am. (2) and (3) (intro.), Register, June, 1998, No. 510, eff. 7-1-98; CR 03-020: am. (1) (intro.), (c), (d) (intro.), 2., (2), (3) (a) to (d), Register April 2004 No. 580, eff. 5-1-04; CR 12-002: am. (1) (c) Register August 2012 No. 680, eff. 9-1-12; CR 15-027: am. (title), (1) (intro.), (a), cr. (1) (e) Register January 2016 No. 721, eff. 2-1-16.*

Chapter PT 2 EXAMINATIONS

PT 2.001 Authority and purpose.

(1) The rules in this chapter are adopted by the board pursuant to the authority delegated by ss. 15.08 (5) (b), 448.53 (1) and 448.54, Stats.

(2) The rules in this chapter are adopted to govern examination of applicants for licensure of physical therapist and physical therapist assistants under ss. 448.53, 448.535, 448.54, and 448.55, Stats. History: CR 12-002: cr. Register August 2012 No. 680, eff. 9-1-12.

PT 2.01 Panel review of applications; examinations required.

(1) All applicants shall complete written examinations. In addition, an applicant may be required to complete an oral examination if the applicant:

(a) Has a medical condition which in any way impairs or limits the applicant's ability to practice physical therapy with reasonable skill and safety.

(b) Uses chemical substances so as to impair in any way the applicant's ability to practice physical therapy with reasonable skill and safety.

(c) Has been diagnosed as suffering from pedophilia, exhibitionism or voyeurism.

(d) Has within the past 2 years engaged in the illegal use of controlled substances.

(e) Has been subject to adverse formal action during the course of physical therapy education, postgraduate training, hospital practice, or other physical therapy employment.

(f) Has been disciplined or had licensure denied by a licensing or regulatory authority in Wisconsin or another jurisdiction.

(g) Has been convicted of a crime the circumstances of which substantially relate to the practice of physical therapy.

(h) Has not practiced as a physical therapist or physical therapist assistant for a period of 3 years prior to application, unless the applicant has been graduated from a school of physical therapy or a physical therapist assistant educational program within that period.

(i) Has been graduated from a physical therapy school or a physical therapist assistant educational program not approved by the board.

(j) Has voluntarily limited the scope of his or her practice as a physical therapist or physical therapist assistant after being the subject of an investigation by a credentialing authority or employer.

(2) An application filed under s. PT 1.03 shall be reviewed by an application review panel consisting of at least 2 board members designated by the chairperson of the board. The panel shall determine whether the applicant is eligible for a regular license without completing an oral examination.

(3) All examinations shall be conducted in the English language.

(4) Where both written and oral examinations are required, they shall be scored separately and the applicant shall achieve a passing grade on both examinations to qualify for a license.

(5) The board shall notify each applicant for examination of the time and place scheduled for that applicant's examination. Failure of an applicant to appear for examination as scheduled will void the applicant's examination application and require the applicant to reapply for examination unless prior scheduling arrangements have been made with the board by the applicant.

(6)

(a) The score required to pass each written physical therapy or physical therapist assistant examination shall be based on the board's determination of the level of examination performance required for minimum acceptable competence in the profession and on the reliability of the examination. The passing grade shall be established prior to giving the examination.

(b) The passing scores for the national physical therapy examination and the national physical therapist assistant examination are those scores recommended by the Federation of State Boards of Physical Therapy.

(c) To pass the examination on statutes and rules, the applicant shall receive a score determined by the board to represent minimum competence to practice after consultation with subject matter experts who have received a representative sample of the examination questions and available candidate performance statistics.

(7) Members of the board shall conduct oral examinations of each candidate and are scored as pass or fail.

(8) Any applicant who is a graduate of a school for physical therapists or an educational program for physical therapist assistants in which English is not the primary language of communication shall take and pass each of the following in order to qualify for a license:

(a) The test of English as a foreign language as administered by the educational testing service.

(b) The test of written English as administered by the educational testing service.

(c) The test of spoken English as administered by the educational testing service.

Note: Under 2001 Wisconsin Act 70, physical therapist assistants are not required to be licensed until April 1, 2004.

History: *Cr. Register, September, 1995, No. 477, eff. 10-1-95; am. (6) (a), r. and recr. (6) (b) and (c), Register, June, 1998, No. 510, eff. 7-1-98; am. (8) (intro.), cr. (8) (a) to (c); Register, April, 2000, No. 532, eff. 5-1-00; CR 03-020: am. (1) (h), (i), (6) (a), (b) and (8) (intro.) Register April 2004 No. 580, eff. 5-1-04; CR 12-002: cr. (1) (j) Register August 2012 No. 680, eff. 9-1-12; CR 15-027: am. (5) Register January 2016 No. 721, eff. 2-1-16.*

PT 2.02 Conduct of examinations. At the start of the examinations, applicants shall be provided with the rules of conduct to be followed during the course of the examinations. Any violation of these rules of conduct by any applicant may be cause for the board to withhold the applicant's grade and to find after a hearing that the applicant has failed the examination.

History: *Cr. Register, September, 1995, No. 477, eff. 10-1-95; am. Register, June, 1998, No. 510, eff. 7-1-98.*

PT 2.03 Failure and reexamination. An applicant who fails to achieve passing grades on the examinations required under this chapter may apply for reexamination on forms provided by the board. For each reexamination, the application shall be accompanied by the reexamination fee. If an applicant for reexamination fails to achieve passing grades on the second reexamination, the applicant may not be admitted to further examination until the applicant reapplies for licensure and presents to the board evidence of further professional training or education as the board may consider appropriate in the applicant's specific case.

Note: A list of all current examination fees may be obtained at no charge from the Office of Examinations, Department of Safety and Professional Services, 1400 East Washington Avenue, P.O. Box 8366, Madison, WI 53708.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95.

Chapter PT 3 TEMPORARY LICENSES

PT 3.001 Authority and purpose. The rules in this chapter are adopted by the board pursuant to the authority delegated by ss. 15.08 (5) (b), 227.11 (2) and 448.53 (2), and 448.55 (3), Stats., and govern the various classes of temporary licenses to practice physical therapy.

History: CR 12-002: cr. Register August 2012 No. 680, eff. 9-1-12.

PT 3.01 Temporary license to practice under supervision, initial licensure.

(1) An applicant for a regular license to practice as a physical therapist or physical therapist assistant, who has not previously been licensed to practice as a physical therapist or as a physical therapist assistant in this state, whichever is applicable, and who is a graduate of an approved school of physical therapy or a physical therapist assistant educational program and has applied to take the national physical therapist examination or the national physical therapist assistant examination and is awaiting results and is not required to take an oral examination, may apply to the board for a temporary license to practice as a physical therapist or physical therapist assistant under supervision. The applications and required documents for a regular license and for a temporary license may be reviewed by 2 members of the board, and upon the finding by the 2 members that the applicant is qualified for admission to examination for a regular license to practice as a physical therapist or physical therapist assistant, the board, acting through the 2 members, may issue a temporary license to practice as a physical therapist or physical therapist assistant under supervision to the applicant.

(2) The required fees specified in s. 440.05 (6), Stats., shall accompany the application for a temporary license to practice under supervision.

Note: Application forms are available upon request to the board office at 1400 East Washington Avenue, P.O. Box 8935, Madison, WI 53708.

(3) The holder of a temporary license to practice physical therapy under supervision may practice physical therapy as defined in s. 448.50 (4), Stats., providing that the entire practice is under the supervision of a person validly holding a regular license as a physical therapist. The supervision shall be direct, immediate, and on premises.

(4) The holder of a temporary license to practice as a physical therapist assistant under supervision may provide physical therapy services as defined by s. 448.50 (4), Stats., providing that the entire practice is under the supervision of a person validly holding a regular license as a physical therapist. The supervision shall be direct, immediate, and on

premises. Note: Under 2001 Wis. Act 70, physical therapist assistants are not required to be licensed until April 1, 2004.

(5) The duration of a temporary license to practice physical therapy under supervision granted under this section shall be for a period of 3 months or until the holder receives failing examination results, whichever is shorter, unless the board grants an extension of the temporary license. A temporary license may be renewed for a period of 3 months, and may be renewed a second time for a period of 3 months for reasons of hardship. Practice under a temporary license may not exceed 9 months total duration.

(6) A physical therapist may supervise no more than a combined total of 4 physical therapists and physical therapist assistants who hold temporary licenses. This number shall be reduced by the number of physical therapist assistants and physical therapy aides being supervised by the physical therapist under s. PT 5.02 (2) (k).

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95; r. and recr. (4), Register, September, 1996, No. 489, eff. 10-1-96; am. (2), Register, June, 1998, No. 510, eff. 7-1-98; r. (5), Register, April, 2000, No. 532, eff. 5-1-00; CR 03-020: am. (1) and (3), renum. (4) to be (5) and am., cr. (6) and (7) Register April 2004 No. 580, eff. 5-1-04; CR 08-049: am. (5) Register November 2008 No. 635, eff. 12-1-08; CR 12-002: am. (1), (4), r. (7) Register August 2012 No. 680, eff. 9-1-12.

Chapter PT 4 LOCUM TENENS LICENSE

PT 4.001 Authority and purpose. The rules in this chapter are adopted by the board pursuant to the authority delegated by ss. 15.08 (5) (b), 227.11 (2), 448.53 (2), and (3), Stats., and govern locum tenens licenses. History: CR 12-002: cr. Register August 2012 No. 680, eff. 9-1-12.

PT 4.01 Locum tenens license.

(1) A person who holds a valid license to practice physical therapy issued by another licensing jurisdiction of the United States may apply to the board for a locum tenens license to practice physical therapy and shall submit to the board all of the following:

(a) A completed and verified application form.

Note: Application forms are available upon request to the board at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708.

(b) A letter of recommendation from a physician or supervisor or present employer stating the applicant's professional capabilities.

(c) A verified photostatic copy of a license to practice physical therapy issued to the applicant by another licensing jurisdiction of the United States.

(d) A letter from a physical therapist licensed in this state requesting the applicant's services, or a letter from an organization or facility in this state requesting the applicant's services.

(e) The required fees specified in s. 440.05 (6), Stats.

(2) The application and documentary evidence submitted by the applicant shall be reviewed by a member of the board, and upon the finding of the member that the applicant is qualified, the board, acting through the member, may issue a locum tenens license to practice physical therapy to the applicant.

(3) The holder of a locum tenens license to practice physical therapy may practice physical therapy as defined in s. 448.56 (1), Stats., providing the practice is confined to the geographical area for which the license is issued.

(4) Except as otherwise ordered by the board, a locum tenens license to practice physical therapy shall expire 90 days from the date of its issuance. For cause shown to its satisfaction, the board may issue a locum tenens license for a period not to exceed 12 months. The locum tenens license is not renewable.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95; am. (1) (e), Register, June, 1998, No. 510, eff. 7-1-98.; r. (1) (d), Register, April, 2000, No. 532, eff. 5-1-00; CR 03-020: cr. (1) (d) Register April 2004 No. 580, eff. 5-1-04; CR 12-002: am. (4) Register August 2012 No. 680, eff. 9-1-12.

Chapter PT 5 PHYSICAL THERAPIST ASSISTANTS AND UNLICENSED PERSONNEL

PT 5.001 Authority and purpose. The rules in this chapter are adopted by the board pursuant to the authority delegated by ss. 15.08 (5) (b), 227.11 (2), and 448.56 (6), Stats., and govern physical therapist assistants and unlicensed personnel.

History: CR 12-002: cr. Register August 2012 No. 680, eff. 9-1-12.

PT 5.01 Practice and supervision of physical therapist assistants.

(1) A physical therapist assistant, as defined in s. 448.50 (3m), Stats., shall assist a physical therapist in the practice of physical therapy under the general supervision of a physical therapist.

(2) In providing general supervision, the physical therapist shall do all of the following:

(a) Have primary responsibility for physical therapy care rendered by the physical therapist assistant.

(b) Have direct face-to-face contact with the physical therapist assistant at least every 14 calendar days, unless the board approves another type of contact.

(c) Remain accessible to telecommunications in the interim between direct contacts while the physical therapist assistant is providing patient care.

(d) Establish a written policy and procedure for written and oral communication. This policy and procedure shall include a specific description of the supervisory activities undertaken for the physical therapist assistant as well as a description of the manner by which the physical therapist shall manage all aspects of patient care. The amount of supervision shall be appropriate to the setting and the services provided.

(e) Provide initial patient examination, evaluation and interpretation of referrals and create the initial patient record for every patient the physical therapist treats.

(f) Develop and revise as appropriate a written patient treatment plan and program.

(g) Delegate appropriate portions of the treatment plan and program to the physical therapist assistant consistent with the physical therapist assistant's education, training and experience.

(h) Provide on-site assessment and reevaluation of each patient's treatment at a minimum of one time per calendar month or every tenth treatment day, whichever is sooner, and adjust the treatment plan as appropriate.

(i) Coordinate discharge plan decisions and the final assessment with the physical therapist assistant.

(j) Limit the number of physical therapist assistants practicing under general supervision to a number appropriate to the setting in which physical therapy is administered, to ensure that all patients under the care of the physical therapist receive services that are consistent with accepted standards of care and consistent with all other requirements

under this chapter. No physical therapist may at any time supervise more than 2 physical therapist assistants full-time equivalents practicing under general supervision.

History: CR 03-020: cr. Register April 2004 No. 580, eff. 5-1-04.

PT 5.02 Supervision of unlicensed personnel.

(1) A physical therapist shall provide direct on-premises supervision of unlicensed personnel at all times. A physical therapist may not direct unlicensed personnel to perform tasks which require the decision making or problem-solving skills of a physical therapist, including but not limited to patient examination, evaluation, diagnosis, or determination of therapeutic intervention.

(2) In providing direct on-premises supervision, the physical therapist shall do all of the following:

(a) Retain full professional responsibility for patient related tasks performed.

(b) Be available at all times for direction and supervision with the person performing related tasks.

(c) Evaluate the effectiveness of patient related tasks performed by those under direct supervision by assessing persons for whom tasks have been performed prior to and following performance of the tasks.

(d) Routinely evaluate the effectiveness of patient related tasks performed by those under direct supervision by observing and monitoring persons receiving such tasks.

(e) Determine the competence of personnel to perform assigned tasks based upon his or her education, training and experience.

(f) Verify the competence of unlicensed personnel with written documentation of continued competence in the assigned tasks.

(g) Perform initial patient examination, evaluation, diagnosis and prognosis, interpret referrals, develop and revise as appropriate a written patient treatment plan and program for each patient and create and maintain a patient record for every patient the physical therapist treats.

(h) Provide interpretation of objective tests, measurements and other data in developing and revising a physical therapy diagnosis, assessment and treatment plan.

(i) Direct unlicensed personnel to provide appropriate patient related tasks consistent with the education, training, and experience of the person supervised. Direction should list specific patient related tasks, including dosage, magnitude, repetitions, settings, length of time, and any other parameters necessary for the performance of the patient related tasks.

(j) Limit the number of unlicensed personnel providing patient related tasks under direct supervision to a number appropriate to the setting in which physical therapy is administered, to ensure that all patients under the care of the physical therapist receive services that are consistent with accepted standards of care and consistent with all other requirements under this chapter.

(k) The total number of physical therapist assistants providing physical therapy services and unlicensed personnel performing patient related tasks under supervision may not exceed a combined total of 4. This number shall be reduced by the number of physical therapists and physical therapist assistants holding temporary licenses who are being supervised under s. PT 3.01 (6).

History: CR 03-020: cr. Register April 2004 No. 580, eff. 5-1-04.

Chapter PT 6 REFERRALS

PT 6.001 **Authority and purpose.** The rules in this chapter are adopted by the board pursuant to the authority delegated by ss. 15.08 (5) (b), 227.11 (2), and 448.56 (1m) (b), Stats., and govern referrals.

History: CR 12–002: cr. Register August 2012 No. 680, eff. 9–1–12.

PT 6.01 Referrals.

(1) In addition to the services excepted from written referral under s. 448.56, Stats., a written referral is not required to provide the following services, related to the work, home, leisure, recreational and educational environments:

(a) Conditioning.

(b) Injury prevention and application of biomechanics.

(c) Treatment of musculoskeletal injuries with the exception of acute fractures or soft tissue avulsions.

(2) A physical therapist providing physical therapy services pursuant to a referral under s. 448.56 (1), Stats., shall communicate with the referring physician, chiropractor, dentist or podiatrist as necessary to ensure continuity of care.

(3) A physical therapist providing physical therapy services to a patient shall refer the patient to a physician, chiropractor, dentist, podiatrist or other health care practitioner under s. 448.56 (1m), Stats., to receive required health care services which are beyond the scope of practice of physical therapy.

History: Cr. Register, September, 1995, No. 477, eff. 10–1–95; am. Register, June, 1998, No. 510, eff. 7–1–98; CR 03–020: renum. to be (1) (intro.) and am., cr. (1) (a) to (c), (2) and (3) Register April 2004 No. 580, eff. 5–1–04.

Chapter PT 7 UNPROFESSIONAL CONDUCT

PT 7.01 Authority and intent.

(1) The definitions of this chapter are adopted by the board pursuant to the authority delegated by ss. 15.085 (5) (b) and 448.527, Stats., to establish the standards of ethical conduct by physical therapists and physical therapist assistants.

(2) Physical therapists and physical therapist assistants are guided by values of accountability, altruism, compassion, caring, excellence, integrity, professional duty, and responsibility. As representatives of the physical therapy profession, they are obligated to empower, educate, and enable patients to facilitate greater independence, health, wellness, and enhanced quality of life. Physical therapists and physical therapist assistants must therefore act, at all times, with honesty, compliance with the law, reasonable judgment, competence, and respect for the patient’s dignity.

History: Cr. Register, September, 1995, No. 477, eff. 10–1–95; CR 03–020: am. Register April 2004 No. 580, eff. 5–1–04; CR 13–007: renum. to (1) and am., cr. (2) Register November 2013 No. 695, eff. 12–1–13.

PT 7.02 Definitions. For the purposes of these rules:

(1) “Negligence in the practice of physical therapy” means an act performed without the care and skill of a reasonable physical therapist or physical therapist assistant who performs the act in question, whether or not the negligent care results in actual harm to the patient.

(2) “Patient health care record” has the meaning given in s. 146.81 (4), Stats.

(3) “Sexual contact” has the meaning given in s. 948.01 (5), Stats.

(4) “Sexually explicit conduct” has the meaning given in s. 948.01 (7), Stats.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95; correction in (18) made under s. 13.93 (2m) (b) 7., Stats.; Register, June, 1998, No. 510; CR 03-020: am. (1), cr. (19), (20) and (21) Register April 2004 No. 580, eff. 5-1-04; CR 13-007: r. and recr. Register November 2013 No. 695, eff. 12-1-13.

PT 7.025 Unprofessional conduct. The term “unprofessional conduct” is defined to include violating, aiding, abetting, or conspiring to engage in any of the following:

(1) Violating s. 448.57 (2) (a) to (g), Stats., other provision of chs. 440 and 448, Stats., or any provision of a board order.

(2) Any physical therapist committing any act that constitutes a violation of the “Code of Ethics,” effective July 1, 2010, as approved by the American Physical Therapy Association and herein incorporated by reference. Note: Copies of the American Physical Therapy Association’s Code of Ethics may be obtained electronically at www.apta.org/ethics.

(3) Any physical therapist assistant committing any act that constitutes a violation of the “Standards of Ethical Conduct,” effective July 1, 2010, as approved by the American Physical Therapy Association and herein incorporated by reference. Note: Copies of the American Physical Therapy Association’s Standards of Ethical Conduct may be obtained electronically at www.apta.org/ethics.

(4) Engaging in fraud, deceit, or misrepresentation in applying for or procuring a license to practice physical therapy, in connection with applying for or procuring periodic renewal of a license, or in otherwise maintaining licensure.

(5) Failing to complete continuing competence requirements within the time period established by law.

(6) Permitting or assisting any person to perform acts constituting the practice of physical therapy without sufficient qualifications, necessary credentials, adequate informed consent, or adequate supervision. The physical therapist is responsible for determining whether general, direct, or one-on-one supervision is necessary to protect the patient from unacceptable risk of harm. The physical therapist retains responsibility for delegated or supervised acts, unless the board determines that the delegate knowingly and willfully violated the supervisor’s direction or instruction.

(7) Engaging in any act of fraud, deceit, or misrepresentation, including acts of omission, to the board or any person acting on the board’s behalf, including Department of Safety and Professional Services personnel.

(8) Any practice or conduct that falls below the standard of minimal competence within the profession that results in unacceptable risk of harm to the patient, regardless of whether injury results.

(9) Negligence in the practice of physical therapy, regardless of whether injury results.

(10) Practicing as a physical therapist or working as a physical therapist assistant when physical or mental abilities are impaired by the use of controlled substances or other habit-forming drugs, chemicals or alcohol, or by other causes.

(11) Practicing physical therapy with a mental or physical condition that impairs the ability of the licensee to practice within the standard of minimal competence or without exposing the patient to an unacceptable risk of harm.

(12) Performing any act constituting the practice of physical therapy on any patient without the patient’s informed consent or after the patient has withdrawn informed consent, whether verbally or in writing, or either of the following:

- (a) Failure to document informed consent.
- (b) Failure to inform the patient that any act of physical therapy may or will be performed by unlicensed personnel.
- (13) Practicing beyond the scope of any professional credential issued by the board or any other state or federal agency.
- (14) Knowingly, negligently, or recklessly making any statement, written or oral, in the course of the practice of physical therapy or as a physical therapist assistant, which is likely to deceive, defraud, mislead, or create an unacceptable risk of harm to the patient or the public or both.
- (15) Divulging a privileged communication or other confidential patient health care information except as required or permitted by state or federal law.
- (16) Engaging in sexually explicit conduct, sexual contact, exposure, gratification, or other sexual behavior with or in the presence of a patient, a patient's immediate family member, or a person responsible for the patient's welfare. For the purposes of this subsection all of the following may apply:
 - (a) Sexual motivation may be determined from the totality of the circumstances and is presumed when the physical therapist or physical therapist assistant has contact with a patient's intimate parts without legitimate professional justification for doing so.
 - (b) An adult receiving treatment shall continue to be a patient for 6 months after the termination of professional services.
 - (c) If the person receiving treatment is a minor, the person shall continue to be a patient for the purposes of this paragraph for 2 years after termination of services or for 2 years after the patient reaches the age of majority, whichever is longer.
 - (d) It is a violation of this paragraph for a physical therapist or physical therapist assistant to engage in any sexual contact or conduct with or in the presence of a patient or former patient who lacks the ability to consent for any reason, including age, medication, or psychological or cognitive disability.
- (17) Illegal or unethical business practices, including either of the following:
 - (a) Fraud, deceit, or misrepresentation in obtaining or attempting to obtain any fee or third-party reimbursement.
 - (b) Engaging in uninvited, in-person solicitation of actual or potential patients who, because of their particular circumstances, are vulnerable to undue influence.
- (18) Providing treatment intervention unwarranted by the condition of the patient or continuing treatment beyond the point of reasonable benefit.
- (19) Violation or conviction of any federal or state law, including criminal law, which is therefore substantially related to the practice of physical therapy and which bars any of the following conduct:
 - (a) Theft or fraud.
 - (b) Violence.
 - (c) Sexual contact with a patient, patient's guardian or family member, or any act performed in the presence of a patient, patient's guardian or family member, for the purposes of sexual gratification.
 - (d) Victimization of children, elderly, or other vulnerable person.
 - (e) Any crime occurring in the course of the practice of physical therapy by a physical therapist or a physical therapist assistant, or in any place in which physical therapy is practiced.

(f) Conclusive evidence of a violation of this subsection shall be a certified copy of any document demonstrating the entry of a guilty plea, nolo contendere plea, alford plea, or entrance into a deferred prosecution agreement, with or without being expunged, pertaining to a crime substantially related to the practice of physical therapy.

(20) Violation or conviction of any federal or state law or rule that is substantially related to the practice of physical therapy. For the purposes of this subsection the following may apply:

(a) Except as otherwise provided by law, a certified copy of a relevant decision by a state or federal court or agency charged with making legal determinations relevant to this paragraph is conclusive evidence of its findings of facts and conclusions of law.

(b) Under this paragraph, the department has the burden of proving that the act is substantially related to the practice of physical therapy.

(21) Failure to establish and maintain accurate and timely patient health care records as required by law and professional standards. Patient health care records are presumed to be untimely if not completed and signed within 60 days of the date of service.

(22) Failure to timely transfer patient health records to any person or practitioner authorized by law to procure the patient health care records. Failure to comply with any lawful request for patient health care records within 30 days of receipt of the request is presumed to be a violation of this subsection.

(23) Having any credential pertaining to the practice of physical therapy result in adverse action by any agency of this or another state, or by any agency or authority within the federal government, which results in any disciplinary action, including limitation, restriction, suspension, revocation, or any other disciplinary action. This paragraph applies whether the adverse action results in temporary or permanent limitation, restriction, suspension, revocation, or disciplinary action. This paragraph applies whether or not the adverse action is accompanied by findings of negligence or unprofessional conduct.

(24) Failure, within 30 days, to report to the board any adverse action, whether final or temporary, taken against the licensee's authority to practice physical therapy as follows:

(a) Any adverse action by another licensing or credentialing jurisdiction concerned with the practice of physical therapy.

(b) Any adverse action by any division of the state or federal government that results in limitation or loss of authority to perform any act constituting the practice of physical therapy or as a physical therapist assistant.

(25) Failure, within 30 days, to report to the board any voluntary agreement to limit, restrict, or relinquish the practice of physical therapy or as a physical therapist assistant entered into with any court or agency of any state or federal government.

(26) Failure to report to the board any incident in which the licensee has direct knowledge of reasonable cause to suspect that a physical therapist or physical therapist assistant has committed any unprofessional, incompetent, or illegal act in violation of state or federal statute, administrative rule, or orders of the board. Reports shall be made within the time necessary to protect patients from further unacceptable risk of harm, but no more than 30 days after the required reporter obtained knowledge of the act. History: CR 13-007: cr. Register November 2013 No. 695, eff. 12-1-13; corrections in (6), (23) made under s. 13.92 (4) (b) 6., Stats., Register November 2013 No. 695.

PT 7.03 **Complaints.** Procedures and requirements for filing complaints with the board are set forth in ch. SPS 2.

History: CR 03–020: cr. Register April 2004 No. 580, eff. 5–1–04; correction made under s. 13.92 (4) (b) 7., Stats., Register November 2011 No. 671.

PT 7.04 **Self-audits.** The board shall biennially review and evaluate its performance in carrying out its responsibilities under this chapter and in other areas over which the board exercises its independent authority, as defined in s. 440.035, Stats.

History: CR 03–020: cr. Register April 2004 No. 580, eff. 5–1–04.

Chapter PT 8 BIENNIAL LICENSE RENEWAL

8.01 **Authority and purpose.** The rules in this chapter are adopted by the board pursuant to the authority delegated by ss. 15.08 (5) (b), 227.11 (2) and 448.53, Stats., and govern biennial renewal of licensees of the board.

History: Cr. Register, September, 1995, No. 477, eff. 10–1–95; am., Register, June, 1998, No. 510, eff. 7–1–98; CR 03–020: am. Register April 2004 No. 580, eff. 5–1–04.

PT 8.02 **Renewal required; method of renewal.** Each licensee shall renew his or her license biennially with the department. Each licensee shall complete a renewal application form and return it with the required fee to the department prior to the next succeeding March 1.

History: Cr. Register, September, 1995, No. 477, eff. 10–1–95; am., Register, June, 1998, No. 510, eff. 7–1–98; CR 13–007: am. Register November 2013 No. 695, eff. 12–1–13; CR 15–027: am. Register January 2016 No. 721, eff. 2–1–16.

PT 8.05 **Requirements for late renewal and reinstatement.** A license shall expire if it is not renewed by March 1 of each odd-numbered year, except for temporary licenses granted pursuant to ch. PT 3. A licensee who allows their license to expire may apply to the board to renew or reinstate their license by completing one of the following:

(1) **RENEWAL BEFORE 5 YEARS.** If the licensee applies for renewal of the license less than 5 years after its expiration, the license shall be renewed upon payment of the renewal fee and completion of the continuing education requirements specified in ch. PT 9.

(2) **RENEWAL AFTER 5 YEARS OR MORE.** If the licensee applies for renewal of the license more than 5 years after its expiration, the board shall make inquiry as it finds necessary to determine whether the applicant is competent to practice under the license in this state, and shall impose any reasonable conditions on renewal of the license, including oral examination, as the board deems appropriate. All applicants under this paragraph shall be required to pass the open book examination on statutes and rules, which is the same examination given to initial applicants. This section does not apply to licensees who have unmet disciplinary requirements or whose licenses have been surrendered or revoked.

(3) **REINSTATEMENT.** A licensee who has unmet disciplinary requirements and failed to renew within 5 years of the renewal date or whose license has been surrendered or revoked, may apply to have the license reinstated in accordance with all of the following:

(a) Evidence of the completion of the requirements under s. PT 8.05 (2).

(b) Evidence of completion of disciplinary requirements, if applicable.

(c) Evidence of rehabilitation or change in circumstances warranting reinstatement of the license.

History: Cr. Register, September, 1995, No. 477, eff. 10-1-95; r. (1), renum. (2) (intro.), (a) and (b) to be (intro.), (1) and (2), Register, June, 1998, No. 510, eff. 7-1-98; CR 12-002: am. (intro.) Register August 2012 No. 680, eff. 9-1-12; CR 15-027: r. and recr. Register January 2016 No. 721, eff. 2-1-16.

Chapter PT 9 CONTINUING EDUCATION

PT 9.01 Authority and purpose. The rules in this chapter are adopted by the board pursuant to the authority delegated by ss. 15.08 (5) (b), 227.11 (2) and 448.55 (3), Stats., and govern required biennial continuing education of licensees of the board.

History: CR 03-020: cr. Register April 2004 No. 580, eff. 5-1-04; CR 12-002: am. Register August 2012 No. 680, eff. 9-1-12.

PT 9.02 Definitions. In this chapter:

(1) “Contact hour” means not less than 50 minutes a licensee spends in actual attendance at or completion of acceptable continuing education.

(1m) “Continuing competence” means the ongoing self assessment, development and implementation of a personal learning plan that evaluates professional knowledge, skill, behavior, and abilities related to the practice of physical therapy.

(2) “Continuing education” means planned, organized learning activities designed to maintain, improve, or expand a licensee’s knowledge and skills relevant to the enhancement of practice, education, or theory development to improve the safety and welfare of the public.

(4) “Licensee” means a person licensed to practice as a physical therapist or physical therapist assistant in this state.

(5) “Remedial education” means education undertaken in lieu of or as part of discipline for the purpose of fulfilling a gap in the licensee’s competence.

History: CR 03-020: cr. Register April 2004 No. 580, eff. 5-1-04; CR 08-049: r. and recr. (1), r. (3) Register November 2008 No. 635, eff. 12-1-08; CR 12-002: cr. (1m), (5) Register August 2012 No. 680, eff. 9-1-12.

PT 9.03 Continuing education requirements.

(1) Unless granted a postponement or waiver under sub. (8), every physical therapist shall complete at least 30 hours of board– approved continuing education in each biennial registration period, as specified in s. 448.55 (3), Stats. Four of the required 30 hours shall be in the area of ethics and jurisprudence.

(2) Unless granted a postponement or waiver under sub. (8), every physical therapist assistant shall complete at least 20 hours of board–approved continuing education in each biennial registration period, as specified in s. 448.55 (3), Stats. Four of the required 20 hours shall be in the area of ethics and jurisprudence.

(3) Continuing education hours may apply only to the registration period in which the hours are acquired. If a license has lapsed, the board may grant permission to apply continuing education hours acquired after lapse of the license to a previous biennial period of licensure during which required continuing education was not acquired. In no case may continuing education hours be applied to more than one biennial period.

(4) Unless granted a postponement or waiver under sub. (8), a licensee who fails to meet the continuing education requirements by the renewal deadline shall cease and desist from practice.

(5) During the time between initial licensure and commencement of a full 2-year licensure period new licensees shall not be required to meet continuing education requirements.

(6) Applicants from other states applying for a license to practice as a physical therapist under s. 448.53 (3), Stats., shall submit proof of completion of at least 30 hours of continuing education approved by the board within 2 years prior to application.

(7) Applicants from other states applying for a license to practice as a physical therapist assistant under s. 448.53 (3), Stats., shall submit proof of completion of at least 20 hours of continuing education approved by the board within 2 years prior to application.

(8) A licensee may apply to the board for a postponement or waiver of the requirements of this section on grounds of prolonged illness or disability, or on other grounds constituting extreme hardship. The board shall consider each application individually on its merits, and the board may grant a postponement, partial waiver or total waiver as deemed appropriate.

Note: Under 2001 Wisconsin Act 70, continuing education requirements do not become effective until the licensing period beginning November 1, 2005 and ending on October 31, 2007.

History: CR 03-020: cr. Register April 2004 No. 580, eff. 5-1-04; CR 08-049: am. (1) and (2) Register November 2008 No. 635, eff. 12-1-08.

PT 9.04 Standards for approval.

(1) To be approved for credit, a continuing education program shall meet all of the following criteria:

(a) The program constitutes an organized program of learning which contributes directly to the professional competency of the licensee.

(b) The program pertains to subject matters which integrally relate to the practice of the profession.

(c) The program is conducted by individuals who have specialized education, training or experience by reason of which the individuals should be considered qualified concerning the subject matter of the activity or program.

(d) The program fulfills pre-established goals and objectives.

(e) The program provides proof of attendance by licensees.

(2) The continuing education activities described in table PT 9.04 qualify for continuing education hours.

TABLE PT 9.04

ACTIVITY CONTACT HOUR LIMITS

(a) Successful completion of relevant academic coursework. No limit. [10 contact hours = one semester credit; 6.6 contact hours = quarter credit]

(b) Attendance at seminars, workshops, lectures, symposia, and professional conferences which are sponsored or approved by acceptable health-related or other organizations including the American Physical Therapy Association and the Wisconsin Physical Therapy Association. No limit.

(c) Successful completion of a self-study course or courses offered via electronic or other means which are sponsored or approved by acceptable health-related or other organizations including the American Physical Therapy Association and the Wisconsin Physical Therapy Association. No limit.

(d) Earning a clinical specialization from the American Board of Physical Therapy Specialties or other recognized clinical specialization certifying organizations. Up to 12 contact hours for initial certification or for recertification.

(e) Authorship of a book about physical therapy or a related professional area. Up to 12 contact hours for each book.

(f) Authorship of one or more chapters of a book about physical therapy or a related professional area. Up to 6 contact hours for each chapter.

(g) Authorship of a presented scientific poster, scientific platform presentation, or published article. Up to 6 contact hours for each poster, platform presentation, or refereed article.

(h) Presenting seminars, continuing education courses, workshops, lectures, or symposia which have been approved by recognized health-related organizations including the American Physical Therapy Association and the Wisconsin Physical Therapy Association.

Note: No additional hours are given for subsequent presentations of the same content. Substantive course revisions may be counted but are limited to the extent of the revision. No limit.

(i) Teaching in an academic course in physical therapy as a guest lecturer.

Note: No additional hours are given for subsequent presentations of the same content. Substantive course revisions may be counted but are limited to the extent of the revision. No limit. [10 contact hours = one semester credit; 6.6 contact hours = one quarter credit]

(j) Teaching in an academic course in physical therapy. Note: No additional hours are given for subsequent presentations of the same content. Substantive course revisions may be counted but are not limited to the extent of the revision. No limit. [10 contact hours = one semester credit; 6.6 contact hours = one quarter credit]

(k) Successful completion in a clinical residency program credentialed by the American Physical Therapy Association or other recognized credentialing organization. No limit.

(l) Attending employer-provided continuing education, including video and non-interactive on-line courses. Up to 15 contact hours for physical therapists. Up to 10 contact hours for physical therapist assistants.

(m) Authoring an article in a non-refereed publication. Up to 5 contact hours.

(n) Developing alternative media materials, including computer software, programs, and video instructional material. 1 contact hour per product. Up to 5 contact hours.

(o) Serving as a clinical instructor for internships with an accredited physical therapist or physical therapist assistant educational program. Up to 15 contact hours for physical therapists. Up to 10 contact hours for physical therapist assistants.

(p) Serving as a supervisor for students fulfilling clinical observation requirements. 1 contact hour per contact hour with students, up to 5 contact hours.

(q) Participating in a physical therapy study group of 2 or more physical therapists or physical therapist assistants or in an interdisciplinary study group of members of at least 2 disciplines meeting on a topic relevant to the participants' work. Up to 2 contact hours per study group.

(r) Participating as a resident or as a mentor in a formal nonacademic mentorship. 1 contact hour per each 8 contact hours for both the resident and mentor, up to 5 contact hours.

(s) Attending a scientific poster session, lecture panel, or a symposium. Up to 2 contact hours.

(t) Serving as a delegate to the American Physical Therapy Association House of Delegates, on a professional committee, board, or task force. Up to 5 contact hours.

(3) The following activities shall not be awarded continuing activity credit:

(a) Meetings for the purpose of policy decisions.

(b) Non-educational meetings at annual association, chapter or organization meetings.

(c) Entertainment or recreational meetings or activities.

(d) Visiting exhibits.

History: CR 03-020: cr. Register April 2004 No. 580, eff. 5-1-04; CR 08-049: renum.

(2) (intro.) to be (2) and am., r. (2) (a) to (c), Table 9.04-1 and Table 9.04-2,

cr. Table 9.04 Register November 2008 No. 635, eff. 12-1-08.

PT 9.05 Proof of attendance at continuing education programs. Applicants for renewal shall be required to certify their attendance at required continuing education programs. The board may conduct a random audit of all licensees on a biennial basis for compliance with continuing education requirements, and shall audit any licensee who is under investigation by the board for alleged misconduct.

History: CR 03-020: cr. Register April 2004 No. 580, eff. 5-1-04.

Chapter PT 10 ORDERING X-RAYS

PT 10.01 Authority and purpose. The rules in this chapter are adopted by the board pursuant to the authority delegated by ss. 15.08 (5) (b) and 448.56 (7) (a), Stats., and specify the qualifications a physical therapist must satisfy to order x-rays.

Note: See also s. 448.56 (7) (b), Stats., relating to coordination of care with the patient's primary care physician or an appropriate health care practitioner.

History: CR 16-089: cr. Register July 2017 No. 739, eff. 8-1-17.

PT 10.02 Qualifications. A physical therapist may order x-rays to be performed by qualified persons if the physical therapist satisfies one of the following qualifications:

(1) The physical therapist holds an entry level clinical doctorate or transitional clinical doctoral degree in physical therapy from a college or university that has a physical therapy program accredited by the Commission on Accreditation in Physical Therapy Education or a successor organization.

(2) The physical therapist has been issued a specialty certification from the American Board of Physical Therapy Specialties. The clinical practice hours leading to the specialty certification shall include training in the practice of ordering x-rays. A specialty certification issued by a national organization other than the American Board of Physical Therapy Specialties satisfies the qualification under this subsection if the certification program meets the criteria under sub. (4) (a) to (f).

(3) The physical therapist has completed a residency or fellowship accredited by the American Board of Physical Therapy Residency and Fellowship Education. The residency or fellowship shall include training in the practice of ordering x-rays. Completion of a residency or fellowship accredited by a national organization other than the American Board of Physical Therapy Residency and Fellowship Education satisfies the qualification under this subsection if the residency or fellowship program meets the criteria under sub. (4) (a) to (f).

(4) The physical therapist has successfully completed a formal x-ray ordering training program meeting all of the following criteria:

(a) The program constitutes an organized program of learning which contributes directly to the professional competency of a licensee to order x-rays.

(b) The program pertains to subject matters which integrally relate to the practice of ordering x-rays.

(c) The program is conducted by individuals who have specialized education, training, or experience by reason of which the individuals should be considered qualified concerning the practice of ordering x-rays. This shall include demonstrated physician involvement in the development or presentation of the program.

(d) The program fulfills pre-established goals and objectives.

(e) The program provides proof of attendance by licensees.

(f) The program includes a final examination or other assessment of a licensee's competency to order x-rays.

History: CR 16-089: cr. Register July 2017 No. 739, eff. 8-1-17.

("Wisconsin", 2016)

APTA Code of Ethics

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Preamble

The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA). The purposes of this Code of Ethics are to:

1. Define the ethical principles that form the foundation of physical therapist practice in patient/client management, consultation, education, research, and administration.
2. Provide standards of behavior and performance that form the basis of professional accountability to the public.
3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities.
4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and

standards that guide the professional conduct of the physical therapist.

5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

No code of ethics is exhaustive nor can it address every situation. Physical therapists are encouraged to seek additional advice or consultation in instances where the guidance of the Code of Ethics may not be definitive.

This Code of Ethics is built upon the five roles of the physical therapist (management of patients/clients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal). Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. Throughout the document the primary core values that support specific principles are indicated in parentheses. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist. Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments, activity limitations, participation restrictions, and disabilities to facilitate greater independence, health, wellness, and enhanced quality of life.

Principle #1: Physical therapists shall respect the inherent dignity and rights of all individuals. (Core Values: Compassion, Integrity)

1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

1B. Physical therapists shall recognize their personal biases and shall not discriminate against others in physical therapist practice, consultation, education, research, and administration.

Principle #2: Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients/clients. (Core Values: Altruism, Compassion, Professional Duty)

2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.

2B. Physical therapists shall provide physical therapy services with compassionate and caring behaviors that incorporate the individual and cultural differences of patients/clients.

2C. Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in clinical research.

2D. Physical therapists shall collaborate with patients/clients to empower them in decisions about their health care.

2E. Physical therapists shall protect confidential patient/client information and may disclose confidential information to appropriate authorities only when allowed or as required by law.

Principle 3: Physical therapists shall be accountable for making sound professional judgments. (Core Values: Excellence, Integrity)

3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's/client's best interest in all practice settings.

3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.

3C. Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.

3D. Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.

3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

Principle 4: Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other healthcare providers, employers, payers, and the public. (Core Value: Integrity)

4A. Physical therapists shall provide truthful, accurate, and relevant information and shall not make misleading representations.

4B. Physical therapists shall not exploit persons over whom they have supervisory, evaluative or other authority (eg, patients/clients, students, supervisees, research participants, or employees).

4C. Physical therapists shall discourage misconduct by healthcare professionals and report illegal or unethical acts to the relevant authority, when appropriate.

4D. Physical therapists shall report suspected cases of abuse involving children or vulnerable adults to the appropriate authority, subject to law.

4E. Physical therapists shall not engage in any sexual relationship with any of their patients/clients, supervisees, or students.

4F. Physical therapists shall not harass anyone verbally, physically, emotionally,

or sexually.

Principle '5: Physical therapists shall fulfill their legal and professional obligations. (Core Values: Professional Duty, Accountability)

5A. Physical therapists shall comply with applicable local, state, and federal laws and regulations.

5B. Physical therapists shall have primary responsibility for supervision of physical therapist assistants and support personnel.

5C. Physical therapists involved in research shall abide by accepted standards governing protection of research participants.

5D. Physical therapists shall encourage colleagues with physical, psychological, or substance related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

5E. Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.

5F. Physical therapists shall provide notice and information about alternatives for obtaining care in the event the physical therapist terminates the provider relationship while the patient/client continues to need physical therapy services.

Principle '6: Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors. (Core Value: Excellence)

6A. Physical therapists shall achieve and maintain professional competence.

6B. Physical therapists shall take responsibility for their professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, healthcare delivery, and technology.

6C. Physical therapists shall evaluate the strength of evidence and applicability of content presented during professional development activities before integrating the content or techniques into practice.

6D. Physical therapists shall cultivate practice environments that support professional development, lifelong learning, and excellence.

Principle '7: Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society. (Core Values: Integrity, Accountability)

7A. Physical therapists shall promote practice environments that support

autonomous and accountable professional judgments.

7B. Physical therapists shall seek remuneration as is deserved and reasonable for physical therapist services.

7C. Physical therapists shall not accept gifts or other considerations that influence or give an appearance of influencing their professional judgment.

7D. Physical therapists shall fully disclose any financial interest they have in products or services that they recommend to patients/clients.

7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapy services accurately reflect the nature and extent of the services provided.

7F. Physical therapists shall refrain from employment arrangements, or other arrangements, that prevent physical therapists from fulfilling professional obligations to patients/clients.

Principle 8: Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally. (Core Values: Social Responsibility)

8A. Physical therapists shall provide pro bono physical therapy services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

8B. Physical therapists shall advocate to reduce health disparities and health care inequities, improve access to health care services, and address the health, wellness, and preventive health care needs of people.

8C. Physical therapists shall be responsible stewards of health care resources and shall avoid overutilization or underutilization of physical therapy services.

8D. Physical therapists shall educate members of the public about the benefits of physical therapy and the unique role of the physical therapist.

(“Code “, 2013)

APTA Guide for Professional Conduct

Purpose

This Guide for Professional Conduct (Guide) is intended to serve physical therapists in interpreting the Code of Ethics for the Physical Therapist (Code) of the American Physical Therapy Association (APTA) in matters of professional conduct. The APTA House of Delegates in June of 2009 adopted a revised Code, which became effective on July 1, 2010. The Guide provides a framework by which physical therapists may

determine the propriety of their conduct. It is also intended to guide the professional development of physical therapist students. The Code and the Guide apply to all physical therapists. These guidelines are subject to change as the dynamics of the profession change and as new patterns of health care delivery are developed and accepted by the professional community and the public.

Interpreting Ethical Principles

The interpretations expressed in this Guide reflect the opinions, decisions, and advice of the Ethics and Judicial Committee (EJC). The interpretations are set forth according to topic. These interpretations are intended to assist a physical therapist in applying general ethical principles to specific situations. They address some but not all topics addressed in the Principles and should not be considered inclusive of all situations that could evolve. This Guide is subject to change, and the Ethics and Judicial Committee will monitor and timely revise the Guide to address additional topics and Principles when necessary and as needed.

Preamble to the Code The Preamble states as follows:

The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA). The purposes of this Code of Ethics are to:

1. Define the ethical principles that form the foundation of physical therapist practice in patient/client management, consultation, education, research, and administration.
2. Provide standards of behavior and performance that form the basis of professional accountability to the public.
3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities.
4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.
5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

No code of ethics is exhaustive nor can it address every situation. Physical therapists are encouraged to seek additional advice or consultation in instances where the guidance of the Code of Ethics may not be definitive.

This Code of Ethics is built upon the five roles of the physical therapist (management of patients/clients, consultation, education, research, and administration), the core values of

the profession, and the multiple realms of ethical action (individual, organizational, and societal). Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. Throughout the document the primary core values that support specific principles are indicated in parentheses. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist.

Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments and activity limitations.

Interpretation: Upon the Code of Ethics for the Physical Therapist being amended effective July 1, 2010, all the lettered principles in the Code contain the word “shall” and are mandatory ethical obligations. The language contained in the Code is intended to better explain and further clarify existing ethical obligations. These ethical obligations predate the revised Code. Although various words have changed, many of the obligations are the same. Consequently, the addition of the word “shall” serves to reinforce and clarify existing ethical obligations. A significant reason that the Code was revised was to provide physical therapists with a document that was clear enough such that they can read it standing alone without the need to seek extensive additional interpretation. The Preamble states that “[n]o Code of Ethics is exhaustive nor can it address every situation.” The Preamble also states that physical therapists “are encouraged to seek additional advice or consultation in instances in which the guidance of the Code may not be definitive.” Potential sources for advice and counsel include third parties and the myriad resources available on the APTA Web site. Inherent in a physical therapist’s ethical decision-making process is the examination of his or her unique set of facts relative to the Code.

Topics

Respect

Principle 1A states as follows:

1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

Interpretation: Principle 1A addresses the display of respect toward others. Unfortunately, there is no universal consensus about what respect looks like in every situation. For example, direct eye contact is viewed as respectful and courteous in some cultures and inappropriate in others. It is up to the individual to assess the appropriateness of behavior in various situations.

Altruism

Principle 2A states as follows:

2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.

Interpretation: Principle 2A reminds physical therapists to adhere to the profession's core values and act in the best interest of patients/clients over the interests of the physical therapist. Often this is done without thought, but sometimes, especially at the end of the day when the physical therapist is fatigued and ready to go home, it is a conscious decision. For example, the physical therapist may need to make a decision between leaving on time and staying at work longer to see a patient who was 15 minutes late for an appointment.

Patient Autonomy

Principle 2C states as follows:

2C. Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in clinical research.

Interpretation: The underlying purpose of Principle 2C is to require a physical therapist to respect patient autonomy. In order to do so, a physical therapist shall communicate to the patient/client the findings of his/her examination, evaluation, diagnosis, and prognosis. A physical therapist shall use sound professional judgment in informing the patient/client of any substantial risks of the recommended examination and intervention and shall collaborate with the patient/client to establish the goals of treatment and the plan of care. Ultimately, a physical therapist shall respect the patient's/client's right to make decisions regarding the recommended plan of care, including consent, modification, or refusal.

Professional Judgment

Principles 3, 3A, and 3B state as follows:

3. Physical therapists shall be accountable for making sound professional judgments. (Core Values: Excellence, Integrity)

3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's/client's best interest in all practice settings.

3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.

Interpretation: Principles 3, 3A, and 3B state that it is the physical therapist's obligation to exercise sound professional judgment, based upon his/her

knowledge, skill, training, and experience. Principle 3B further describes the physical therapist's judgment as being informed by three elements of evidence-based practice.

With regard to the patient/client management role, once a physical therapist accepts an individual for physical therapy services he/she shall be responsible for: the examination, evaluation, and diagnosis of that individual; the prognosis and intervention; re-examination and modification of the plan of care; and the maintenance of adequate records, including progress reports. A physical therapist shall establish the plan of care and shall provide and/or supervise and direct the appropriate interventions. Regardless of practice setting, a physical therapist has primary responsibility for the physical therapy care of a patient and shall make independent judgments regarding that care consistent with accepted professional standards. If the diagnostic process reveals findings that are outside the scope of the physical therapist's knowledge, experience, or expertise, or that indicate the need for care outside the scope of physical therapy, the physical therapist shall so inform the patient/client and shall refer the patient/client to an appropriate practitioner.

A physical therapist shall determine when a patient/client will no longer benefit from physical therapy services. When a physical therapist's judgment is that a patient will receive negligible benefit from physical therapy services, the physical therapist shall not provide or continue to provide such services if the primary reason for doing so is to further the financial self-interest of the physical therapist or his/her employer. A physical therapist shall avoid overutilization of physical therapy services. See Principle 8C.

Supervision

Principle 3E states as follows:

3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

Interpretation: Principle 3E describes an additional circumstance in which sound professional judgment is required; namely, through the appropriate direction of and communication with physical therapist assistants and support personnel. Further information on supervision via applicable local, state, and federal laws and regulations (including state practice acts and administrative codes) is available. Information on supervision via APTA policies and resources is also available on the APTA Web site. See Principles 5A and 5B.

Integrity in Relationships

Principle 4 states as follows:

4. Physical therapists shall demonstrate integrity in their relationships with

patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public. (Core Value: Integrity)

Interpretation: Principle 4 addresses the need for integrity in relationships. This is not limited to relationships with patients/clients, but includes everyone physical therapists come into contact with professionally. For example, demonstrating integrity could encompass working collaboratively with the health care team and taking responsibility for one's role as a member of that team.

Reporting

Principle 4C states as follows:

4C. Physical therapists shall discourage misconduct by healthcare professionals and report illegal or unethical acts to the relevant authority, when appropriate.

Interpretation: When considering the application of “when appropriate” under Principle 4C, keep in mind that not all allegedly illegal or unethical acts should be reported immediately to an agency/authority. The determination of when to do so depends upon each situation's unique set of facts, applicable laws, regulations, and policies. Depending upon those facts, it might be appropriate to communicate with the individuals involved. Consider whether the action has been corrected, and in that case, not reporting may be the most appropriate action. Note, however, that when an agency/authority does examine a potential ethical issue, fact finding will be its first step. The determination of ethicality requires an understanding of all of the relevant facts, but may still be subject to interpretation. The EJC Opinion titled Topic: Preserving Confidences; Physical Therapist's Reporting Obligation With Respect to Unethical, Incompetent, or Illegal Acts provides further information on the complexities of reporting.

Exploitation

Principle 4E states as follows:

4E. Physical therapists shall not engage in any sexual relationship with any of their patient/clients, supervisees, or students.

Interpretation: The statement is fairly clear – sexual relationships with their patients/clients, supervisees, or students are prohibited. This component of Principle 4 is consistent with Principle 4B, which states:

Physical therapists shall not exploit persons over whom they have supervisory, evaluative, or other authority (e.g. patients/clients, students, supervisees, research participants, or employees).

Next, consider this excerpt from the EJC Opinion titled Topic: Sexual Relationships With Patients/Former Patients:

A physical therapist stands in a relationship of trust to each patient and has an ethical obligation to act in the patient's best interest and to avoid any exploitation or abuse of the patient. Thus, if a physical therapist has natural feelings of attraction toward a patient, he/she must sublimate those feelings in order to avoid sexual exploitation of the patient. One's ethical decision-making process should focus on whether the patient/client, supervisee, or student is being exploited. In this context, questions have been asked about whether one can have a sexual relationship once the patient/client relationship ends. To this question, the EJC has opined as follows:

The Committee does not believe it feasible to establish any bright-line rule for when, if ever, initiation of a romantic/sexual relationship with a former patient would be ethically permissible. The Committee imagines that in some cases a romantic/sexual relationship would not offend ... if initiated with a former patient soon after the termination of treatment, while in others such a relationship might never be appropriate.

Colleague Impairment

Principle 5D and 5E state as follows:

5D. Physical therapists shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

5E. Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report the information to the appropriate authority.

Interpretation: The central tenet of Principles 5D and 5E is that inaction is not an option for a physical therapist when faced with the circumstances described. Principle 5D states that a physical therapist shall encourage colleagues to seek assistance or counsel while Principle 5E addresses reporting information to the appropriate authority. Principles 5D and 5E both require a factual determination on your part. This may be challenging in the sense that you might not know or it might be difficult for you to determine whether someone in fact has a physical, psychological, or substance-related impairment. In addition, it might be difficult to determine whether such impairment may be adversely affecting his or her professional responsibilities. Moreover, once you do make these determinations, the obligation under 5D centers not on reporting, but on encouraging the colleague to seek assistance. However, the obligation under 5E does focus on reporting. But note that 5E discusses reporting when a colleague is unable to perform, whereas 5D discusses encouraging colleagues to seek assistance when the impairment may adversely affect his or her professional responsibilities. So, 5D discusses something that may be affecting performance, whereas 5E addresses a situation in which someone is clearly unable to perform. The 2 situations are distinct. In addition, it is important to note that 5E does not mandate to whom you

report; it gives you discretion to determine the appropriate authority.

The EJC Opinion titled: Topic: Preserving Confidences; Physical Therapist's Reporting Obligation With Respect to Unethical, Incompetent, or Illegal Acts provides further information on the complexities of reporting.

Professional Competence

Principle 6A states as follows:

6A. Physical therapists shall achieve and maintain professional competence.

Interpretation: 6A requires a physical therapist to maintain professional competence within one's scope of practice throughout one's career. Maintaining competence is an ongoing process of self-assessment, identification of strengths and weaknesses, acquisition of knowledge and skills based on that assessment, and reflection on and reassessment of performance, knowledge, and skills. Numerous factors including practice setting, types of patients/clients, personal interests, and the addition of new evidence to practice will influence the depth and breadth of professional competence in a given area of practice. Additional resources on Continuing Competence are available on the APTA Web site.

Professional Growth

Principle 6D states as follows:

6D. Physical therapists shall cultivate practice environments that support professional development, lifelong learning, and excellence.

Interpretation: 6D elaborates on the physical therapist's obligations to foster an environment conducive to professional growth, even when not supported by the organization. The essential idea is that this is the physical therapist's responsibility, whether or not the employer provides support.

Charges and Coding

Principle 7E states as follows:

7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapy services accurately reflect the nature and extent of the services provided.

Interpretation: Principle 7E provides that the physical therapist must make sure that the process of documentation and coding accurately captures the charges for services performed. In this context, where charges cannot be determined because of payment methodology, physical therapists may review the House of Delegates policy titled Professional Fees for Physical Therapy Services. Additional

resources on documentation and coding include the House of Delegates policy titled Documentation Authority for Physical Therapy Services and the Documentation and Coding and Billing information on the APTA Web site.

Pro Bono Services

Principle 8A states as follows:

8A. Physical therapists shall provide pro bono physical therapy services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

Interpretation: The key word in Principle 8A is “or.” If a physical therapist is unable to provide pro bono services he or she can fulfill ethical obligations by supporting organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured. In addition, physical therapists may review the House of Delegates guidelines titled Guidelines: Pro Bono Physical Therapy Services. Additional resources on pro bono physical therapy services are available on the APTA Web site.

Principle 8A also addresses supporting organizations to meet health needs. In terms of supporting organizations, the principle does not specify the type of support that is required. Physical therapists may express support through volunteerism, financial contributions, advocacy, education, or simply promoting their work in conversations with colleagues. (APTA, 2013)

Case Examples

- During a continuing education course, a fellow physical therapy participant tells a story about trying an untested ointment modality on a patient with some success. Upon returning to work, you find that you have a similar patient. What do you do?
 - Though the modality tried by the fellow colleague appeared to have positive results, you should choose to use equipment, techniques, and data that have been evidence-based and recognized within the field of physical therapy.
- A PT is planning on taking a vacation with plans for the PTA to cover her patients while she is gone. While reviewing her files, she notices that a patient will be due for a re-evaluation during the time she is scheduled off. What should be done?
 - The PT will need to complete the re-evaluation before her vacation as this is a task that the PTA is unable to do. Best practice will be getting the re-evaluation done before it is overdue.
- A famous hockey player has just been admitted to your practice. Everyone in the office is buzzing with excitement. “What room is he in?” “What are his injuries?”

“I wonder if he will be able to finish this season?” Should you engage in the discussion?

- Engaging in discussions that disclose a person's identity, as well as condition, are clear contradictions to the principle of 2E, which states physical therapists shall protect confidential patient/client information and may disclose confidential information to appropriate authorities only when allowed as required by law. Any behavior similar to this example should be avoided.
- You've recently registered a new patient who no longer drives. In order to come to his visits, he must arrange rides through a service that offers rides for disabled clients. What APTA core value does this uphold?
 - Coordinating appointment dates and times with the ride service and completing the paperwork they require is an example demonstrating the APTA's core value of social responsibility by advocating for patients' rights to access necessary transportation services.
- A new patient comes in for an evaluation. The patient is in severe pain. Should the physical therapist start treating the pain or complete the evaluation first?
 - Physical therapy treatment may not be provided prior to the completion of an evaluation of the patient's condition by a PT. Despite how much pain the patient is in, the physical therapist must attempt to complete as much of the evaluation as possible to understand the condition they are dealing with.
- You have been practicing physical therapy in Wisconsin under a Locum Tenens license for the past two months and plan to continue for at least six more months. What steps do you need to take to ensure you are in compliance?
 - Unless you receive a special exception a Locum Tenens license is only valid for 90 days and is not renewable. You will need to apply for a full Wisconsin license.
- A child has been receiving physical therapy for 5 years for a brain trauma injury. The parents want the child to continue physical therapy services although clearly the progress notes and records do not reflect significant improvement the past 6 months. Should the PT continue treating the patient?
 - Recording or documenting improvements such so that continued care will be authorized and reimbursed is in contradiction to principle 3A and 3B, demonstrates poor professional judgment, and has subsequent legal ramifications.
- At your new job, you are required to provide supervision for 2 PTAs and one rehab tech. Your director would like to hire two more rehab techs and would like you to provide supervision for them as well. What should your response be?
 - Wisconsin allows a licensed therapist to supervise up to 2 PTAs and up to 4 unlicensed staff such as rehab techs. However, a PT may only supervise 4 individuals in total, so you would not be able to supervise 2 additional

rehab techs.

- One of your patients frequents a chiropractor for a condition unrelated to the carpal tunnel syndrome you are treating. This clinic utilizes a modality that you are not familiar with. How should you address this with your patient?
 - Rather than expressing your doubts regarding this modality; honor the patient's autonomy (principle 2C) and right to make treatment decisions on their own behalf and respect the chiropractor's treatment as valid and complementary.

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