

FLEX CEUs



Ethics for the Pennsylvania Physical Therapist



RIGHT DOING

WRONG DOING

Ethics for the Pennsylvania Physical Therapist

OUTLINE

- Course Outline..... 1
- Introduction & Instructor Biography..... 2
- Importance of Ethics..... 2
- Ethical Approaches..... 3
- Ethics vs. Morals..... 4
- Role of Regulation..... 6
- Direct Access to Services..... 9
- APTA Code of Ethics..... 10
 - Principal #1..... 11
 - Principal #2..... 11
 - Principal #3..... 12
 - Principal #4..... 12
 - Principal #5..... 13
 - Principal #6..... 13
 - Principal #7..... 13
 - Principal #8..... 14
- APTA Guide for Professional Conduct..... 14
 - Respect..... 16
 - Altruism..... 16
 - Patient Autonomy..... 16
 - Professional Judgment..... 17
 - Supervision..... 18
 - Integrity in Relationships..... 18
 - Exploitation..... 19
 - Colleague Impairment..... 19
 - Professional Competence..... 20
 - Professional Growth..... 20
 - Charges and Coding..... 20
 - Pro Bono Services..... 21
- Application of Content/Case Studies..... 21
- References..... 23

Introduction

This course fulfills the 2 hour continuing competency requirements for ethics, laws and regulations for physical therapists practicing in the state of Pennsylvania. 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).

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 (Garcia 1991). 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 any one 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!"(Hippocrates 400 B.C.E.)

Ethical Dilemmas

Ethical dilemmas are issues and situations that come up, that cause friction against the primary code of ethics Physical Therapists are held to following. There doesn't need to be a nefarious plot to find an ethical dilemma. It can be as innocent as a conflict between state and county guidelines or bringing older standards and therapeutic equipment up to current standards. Physical Therapy works specifically in the care and well-being of human beings. As such, maintaining and keeping healthy and professional boundaries and clear communication are integral to the health care field. "Do No Harm" is not a term to throw around lightly, but holds 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 up 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 till 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, J. 2009).

- **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 (Tabor, H. 2008)? 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?
- **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 Deontologic 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 (and other legal matters). ("Ethical Intuitionism". 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." (Harris, C.E. 2002).

Ethics Versus Morals

Morals presuppose that there is a definite "right" and "wrong" way to live life. Morals may become so popular amongst a group of people that they become chiseled onto stone tablets or copied into books. In comparison, ethics rely more upon reasoning versus a definite "right" and "wrong". Ethics may help guide morals. One may reason and come to an ethical decision which then helps a person deal with a transgression to help them morally.

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 the Ethical path, 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 working and behaving with pure intention. One can look to Disney stories for references of “a true and pure heart” which is always required to win true love or to defeat an enemy. Dr. Edmund D. Pellegrino speaks to this when he says, “Nothing more exposes a physician's true ethics than the way he or she balances his or her own interests against those of the patient. Whether the physician is refusing to care for patients with the acquired immunodeficiency syndrome (AIDS) for fear of contagion or withdrawing from emergency department service for fear of malpractice suits, striking for better pay or fees, or earning a gatekeeper's bonus by blocking access to medical care, the question raised is the same.” (Pellegrino, E. 1987).

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 knows 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

So, why be ethical? Operating within ethical standards keeps you in business. While we looked at all of the values, the virtues, and the morals of operating within an ethical model, the bottom line is: It keeps your patients safe and your business secure. While there will be local, cultural, and practical variations, the standards within the Code of Ethics are recognized throughout the world.

Bioethical Concerns and HIPAA

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 “natural” occurring for humans, but the result of human engineering. There is great debate among cultures and religious groups who have moral objections to invasive procedures.

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. (Thacker, S. 2003).

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 the 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 subchapter C of the Pennsylvania State Board of Physical Therapy code.

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. Pennsylvania is one of those states. Physical therapists can apply for a certificate of authorization to practice physical therapy without a referral. Chapter 40 (State Board of Physical Therapy) of the Pennsylvania Code sets forth specific requirements that must be followed in order to obtain this certificate. These requirements also include restrictions on duration of treatment prior to consulting a patient's physician as well as types of conditions that cannot be treated without a referral unless first consulting the patient's physician, dentist or podiatrist.

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 physical therapist 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, there is absolutely no evidence that physical therapists 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 against physical therapists filed 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 the research study titled "Documentation of red flags by physical therapists for patients with low back pain," studied the frequency of medical screening procedures in 6 private practice clinics (Leerar 2007). In this retrospective chart review of 160 patients admitted with low back pain, they found that an average of 8 out of the 11 recommended "red flag" screening questions were documented in the chart. The authors noted that this was comparable to or exceeded that of physicians in 5 other studies. In another study, Boissonault et al 3. reported on 81 patients seen under direct access in a nonprofit, hospital-based outpatient department, and found that retrospective physician review of physical therapist management decisions determined that physical therapist decisions were appropriate 100% of the time (Boissonault 2010). These decisions included making referrals for

additional imaging studies, medical consultation, and medication for pain management. Most referrals from physicians are written as “evaluate and treat.” Medical “diagnoses” may only be basket-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. Improved patient access does not harm the relationships between physical therapists and physicians. Direct access supports a collaborative model of practice between physicians and physical therapists and will create opportunities that can only 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.

APTA Code of Ethics

The following information regarding the American Physical Therapy Association has been reprinted from http://www.npta.org/pdf/134_Todays-Physical-Therapy-Profession.pdf with permission of the American Physical Therapy Association. This material is copyrighted, and any further reproduction or distribution requires written permission from the APTA (American 2010).

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 (e.g., 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, life-long 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 over-utilization or under-utilization 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.

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, activity limitations, participation

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. 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, life-long 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.

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.

Case Examples

- 1) 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.
- 2) A patient is scheduled to see the PTA. The PTA realizes when the patient is at the office that it has been 35 days since the patient has started physical therapy. What should be done? The patient will need to be rescheduled with a physical therapist so that the physical therapist is able to perform a reevaluation. Pennsylvania state regulations dictate that when patient-care services are provided by the physical therapist assistant, the physical therapist shall document reevaluations and adjustments to a patient plan of care and goals at least every 30 calendar days or when there is a significant change in patient status warranting an earlier patient evaluation (The Pennsylvania Code § 40.53). Provision of physical therapy treatment by a PTA or an aide may not continue if the PT has not performed the required reevaluation.
- 3) In a social setting, a close friend mentions she saw a famous hockey player exiting your practice. She is full of questions! “Was that who I thought it was leaving your clinic

Monday”? “What are his injuries?” “I wonder if he will be able to finish this season.” 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.

- 4) 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. 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.
- 5) A physical therapist with a certification of authorization to practice physical therapy without a referral has been treating a patient for a knee sprain for 30 days and the patient is progressing well towards their short term goals. Is it appropriate to continue treatment considering the positive results of therapy? According to the Pennsylvania Code, a physical therapist may not treat an individual beyond 30 days from the date of the first treatment unless the individual has obtained a referral from a licensed physician, a licensed physician assistant practicing under a written agreement, a certified registered nurse practitioner practicing under a collaborative agreement, a licensed dentist for the treatment of a condition that is within the scope of practice of dentistry or a licensed podiatrist for the treatment of a condition that is within the scope of practice of podiatry (Pennsylvania Code, § 40.61).
- 6) 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 progressive notes and records do not reflect significant improvement the past 6 months. Recording or documenting improvements such so that continued care will be authorized and reimbursed is in contradiction to principle 3 a&b, demonstrates poor professional judgment and has subsequent legal ramifications.
- 7) You have a patient with elbow tendinitis that you feel may benefit from transdermal delivery of dexamethasone via ultrasound. There is a small portion in the supply cabinet that you are considering using to determine if the patient obtains any relief from the medication's anti-inflammatory properties. Use of a prescriptive medication for anyone other than the prescribed patient is a clear ethical violation. After discharge of a patient in which a prescribed, transdermal medication has been used, the remaining drugs must be disposed of by the physical therapist or returned to the patient.

References

- American Physical Therapy Association, (October 1981; Last Amended November 2010; Last Updated 11/30/10). Today's Physical Therapist: A Comprehensive Review of a 21st-Century Health Care Profession.
- Boissonault, W.G., Badke, M.B., & Powers, J.M (2010). Pursuit and Implementation of Hospital-Based Outpatient Direct Access to Physical Therapy Services: An Administrative Case Report. *Journal of the American Physical Therapy Association*, 90, 100-109.
- "Deontological ethics". Encyclopedia Britannica. Retrieved May 21, 2014 from <http://www.britannica.com> .
- Driver, J. (2009, June 16). The History of Utilitarianism. Retrieved from <http://plato.stanford.edu> .
- "Ethical Intuitionism". Wikipedia. Retrieved May 21, 2014 from <http://www.wikipedia.org>.
- "Ethics". Dictionary Online. Retrieved May 12, 2014, from <http://dictionary.reference.com>.
- Garcia, J. (1991). Civilization and Ethics. Retrieved from <http://www.see.org>.
- Harris, C.E. (2002). Deontological Theories: Natural Law. Retrieved from <http://www.qcc.cuny.edu>.
- Hippocrates. (400 B.C.E). The Oath. Retrieved May 27, 2015 from <http://classics.mit.edu>.
- Leerar, P.J., Boissonault, W., Domholdt, E., & Roddey, T. (2007). Documentation of Red Flags by Physical Therapists with Low Back Pain. *The Journal of Manual & Manipulative Therapy*, 15, 42-49.
- Morality". Dictionary online. Retrieved May 21, 2014 from <http://www.dictionary.reference.com>.
- Pellegrino, E. (1987). Altruism, Self-Interest, and Medical Ethics. Retrieved from <http://www.jama.com>.
- The Pennsylvania Code. Chapter 40 State Board of Physical Therapy. § 40.53 and § 40.61.

FLEX CEUs



"This course was developed from the document: Ethics for the Pennsylvania Physical Therapist. Some portion of this information has been reprinted with permission of The American Physical Therapy Association .
http://www.npta.org/pdf/134_Todays-Physical-Therapy-Profession.pdf. This material is copyrighted, and any further reproduction or distribution requires written permission from the APTA (American 2010)."