

## Ethics & Jurisprudence – Indiana Physical Therapy

### Goals & Objectives

#### Course Description

“Ethics and Jurisprudence – Indiana Physical Therapy” is an asynchronous text-based online continuing education program for Indiana licensed physical therapists and physical therapist assistants. The course focuses on defining moral, ethical, and legal behavior of physical therapy professionals. The information presented includes the APTA’s Code of Ethics, Standards of Ethical Conduct for the PTA, Guide for Professional Conduct for Physical Therapists and Assistants, Indiana Code article 25-27, Title 842 Article 1 Indiana Board of Physical Therapy Rules, model for ethical decision making, and hypothetical case analysis.

#### Course Rationale

This course is designed to educate, promote, and facilitate ethical and legal behavior by Indiana licensed physical therapists and physical therapist assistants. It is intended to fulfill the 2-hour Ethics & Jurisprudence CE requirement as defined by Title 842 Article 1 Indiana Board of Physical Therapy Rule 7(842 IAC 1-7-1(a)).

#### Course Goals & Objectives

At the end of this course, the participants will be able to:

1. define the meaning of ethics and explain the various theories that promote ethical behavior.
2. identify the components of the ethical decision-making model
3. interpret and apply the APTA’s Code of Ethics
4. interpret and apply the APTA’s Standards of Ethical Conduct for the PTA
5. identify and interpret the statutes of Indiana Code Article 25-27
6. identify and apply the regulations of Title 842 Article 1 Indiana Board of Physical Therapy Rules.
7. differentiate between ethical/unethical and legal/illegal professional behavior in physical therapy practice
8. Identify and review current peer-reviewed evidence relating to ethical and legal behavior of physical therapy professionals

**Course Provider** – Innovative Education Services

**Course Instructor** - Michael Niss, DPT

**Target Audience** - Indiana licensed physical therapists and physical therapist assistants

**Level of Difficulty** – This course is applicable for introductory/intermediate/advanced learners.

**Course Prerequisites** - None

**Method of Instruction/Availability** – Online text-based course available continuously

**Criteria for Issuance of CE Credits** – A score of 70% or greater on the course post-test

**Continuing Education Credits** – Two (2) hours of continuing education credit.

**Course Fee** - \$4.95

**Conflict of Interest** – No conflict of interest exists for the presenter or provider of this course. The presenter attests that they will avoid any intentional self-promotion or promotion of any product or services in which they have a vested interest.

**Refund Policy** - Unrestricted 100% refund upon request. The request for a refund by the learner shall be honored in full without penalty or other consideration of any kind. The request for a refund may be made by the learner at any time without limitations before, during, or after course participation.

## Ethics & Jurisprudence – Indiana Physical Therapy

### Course Outline

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## Ethics Overview

The word “ethics” is derived from the Greek word *ethos* (character), and from the Latin word *mores* (customs). Together, they combine to define how individuals choose to interact with one another. In philosophy, ethics defines what is good for the individual and for society and establishes the nature of duties that people owe themselves and one another. Ethics is also a field of human inquiry (“science” according to some definitions) that examines the bases of human goals and the foundations of “right” and “wrong” human actions that further or hinder these goals.

Ethics are important on several levels.

- People feel better about themselves and their profession when they work in an ethical manner.
- Professions recognize that their credibility rests not only on technical competence, but also on public trust.
- At the organizational level, ethics is good business. Several studies have shown that over the long run ethical businesses perform better than unethical businesses.

### Ethics vs. Morals

Although the terms “ethics” and “morals” are often used interchangeably, they are not identical. Morals usually refer to practices; ethics refers to the rationale that may or may not support such practices. Morals refer to actions, ethics to the reasoning behind such actions. Ethics is an examined and carefully considered structure that includes both practice and theory. Morals include ethically examined practices but may also include practices that have not been ethically analyzed, such as social customs, emotional responses to breaches of socially accepted practices and social prejudices. Ethics is usually at a higher intellectual level, more universal, and more dispassionate than morals. Some philosophers, however, use the term “morals” to describe a publicly agreed-upon set of rules for responding to ethical problems.

### Ethical Questions

Ethical questions involve 1) responsibilities to the welfare of others or to the human community; or 2) conflicts among loyalties to different persons or groups, among responsibilities associated with one’s role (e.g. as consumer or provider), or among principles. Ethical questions include (or imply) the words “ought” or “should”.

## **Ethics Theories**

Throughout history, mankind has attempted to determine the philosophical basis from which to define right and wrong. Here are some of the more commonly accepted theories that have been proposed.

### **Utilitarianism**

This philosophical theory develops from the work of Jeremy Bentham and John Stuart Mill. Simply put, utilitarianism is the theory that right and wrong is determined by the consequences. The basic tool of measurement is pleasure (Bentham) or happiness (Mill). A morally correct rule was the one that provided the greatest good to the greatest number of people.

### **Social Contract Theory**

Social contract theory is attributed to Thomas Hobbes, John Locke, and from the twentieth century, John Rawls. Social contract theories believe that the moral code is created by the people who form societies. These people come together to create society for the purpose of protection and gaining other benefits of social cooperation. These persons agree to regulate and restrict their conduct to achieve this end.

### **Deontological or Duty Theory**

Under this theory you determine if an act or rule is morally right or wrong if it meets a moral standard. The morally important thing is not consequences, but the way choosers think while they make choices. One famous philosopher who developed such a theory was Immanuel Kant (1724-1804).

### **Ethical Intuitionism**

Under this view an act or rule is determined to be right or wrong by appeal to the common intuition of a person. This intuition is sometimes referred to as your conscience. For example- anyone with a normal conscience will know that it is wrong to kill an innocent person.

### **Ethical Egoism**

This view is based on the theory that each person should do whatever promotes their own best interests; this becomes the basis for moral choices.

### **Natural Law Theory**

This is a moral theory which claims that just as there are physical laws of nature, there are moral laws of nature that are discoverable. This theory is largely associated with Aristotle and Thomas Aquinas, who advocated that each thing has its own inherent nature, i.e. characteristic ways of behavior that belong to all members of its species and are appropriate to it. This nature determines what is good or bad for that thing. In the case of human beings, the moral laws of nature

stem from our unique capacity for reason. When we act against our own reason, we are violating our nature, and therefore acting immorally.

### **Virtue Ethics**

This ethics theory proposes that ethical behavior is a result of developed or inherent character traits or virtues. A person will do what is morally right because they are a virtuous person. Aristotle was a famous exponent of this view. Aristotle felt that virtue ethics was the way to attain true happiness. These are some of the commonly accepted virtues.

**Autonomy:** the duty to maximize the individual's right to make his or her own decisions.

**Beneficence:** the duty to do good.

**Confidentiality:** the duty to respect privacy of information.

**Finality:** the duty to take action that may override the demands of law, religion, and social customs.

**Justice:** the duty to treat all fairly, distributing the risks and benefits equally.

**Nonmaleficence:** the duty to cause no harm.

**Understanding/Tolerance:** the duty to understand and to accept other viewpoints if reason dictates.

**Respect for persons:** the duty to honor others, their rights, and their responsibilities.

**Universality:** the duty to take actions that hold for everyone, regardless of time, place, or people involved.

**Veracity:** the duty to tell the truth.

### **Model for Ethical Decision Making**

The foundation for making proper ethical decisions is rooted in an individual's ability to answer several fundamental questions concerning their actions.

#### **Are my actions legal?**

Weighing the legality of one's actions is a prudent way to begin the decision-making process. The laws of a geographic region are a written code of that region's accepted rules of conduct. This code of conduct usually defines clearly which actions are considered acceptable and which actions are unacceptable. However, a legitimate argument can be made that sometimes what is legal is not always moral, and that sometimes what is moral is not always legal. This idea is easily demonstrated by the following situation.

It is illegal for a pedestrian to cross a busy street anywhere other than at the designated crosswalk (jaywalking). A man is walking down a street and sees someone fall and injure themselves on the other side of the street. He immediately crosses the street outside of the crosswalk to attend to the injured person. Are his actions legal? Are they moral? What if by stepping into the street he causes a car to swerve and to strike another vehicle?

Admittedly, with the exception of policemen and attorneys, most people do not know all of the specific laws that govern their lives. However, it is assumed that most people are familiar with the fundamental virtues from which these laws are based, and that they will live their lives in accordance with these virtues.

### **Are my actions ethical?**

Professional ethical behavior as it is defined in this context relates to actions that are consistent with the normative standards established or practiced by others in the same profession. For physical therapists and physical therapist assistants, these ethical standards are documented in the APTA's Code of Ethics. All PT's and PTA's, even those who are not members of the APTA, are bound to these guidelines. This is because The APTA Code of Ethics is the accepted and de facto standard of practice throughout the profession.

### **Are my actions fair?**

I think most people would agree that the concept of fairness is often highly subjective. However, for these purposes, we will define fairness as meaning deserved, equitable and unbiased. Fairness requires the decision-maker to have a complete understanding of benefits and liabilities to all parties affected by the decision. Decisions that result in capricious harm or arbitrary benefit cannot be considered fair. The goal of every decision should be an outcome of relative equity that reflects insightful thought and soundness of intent.

### **Would my actions be the same if they were transparent to others?**

This question presents as a true reflection of the other three. Legal, ethical, and fair are defined quite differently by most people when judged in the comfort of anonymity versus when it is examined before the forum of public opinion. Most often it is the incorrect assumption that "no one will ever find out about this" that leads people to commit acts of impropriety. How would your decisions change, if prior to taking any actions, you assumed just the opposite; "other people will definitely know what I have done". One sure sign of a poor decision is debating the possible exposure of an action instead of examining the appropriateness of it.

## APTA Code of Ethics

### 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.

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. 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.

### Principles

#### ***Principle #1:***

*Physical therapists shall respect the inherent dignity and rights of all individuals.*

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.*

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.*

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 health care providers, employers, payers, and the public.*

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 not engage in any sexual relationship with any of their patients and clients, supervisees, or students.

4D. Physical therapists shall not harass anyone verbally, physically, emotionally, or sexually.

4E. Physical therapists shall discourage misconduct by physical therapists, physical therapist assistants, and other health care professionals and, when appropriate, report illegal or unethical acts, including verbal, physical, emotional, or sexual harassment, to an appropriate authority with jurisdiction over the conduct.

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

**Principle #5:**

*Physical therapists shall fulfill their legal and professional obligations.*

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 therapist services.

**Principle #6:**

*Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors.*

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, health care 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.*

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.*

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.

## **APTA's Guide for Professional Conduct**

The APTA's Guide for Professional Conduct is produced to assist physical therapists in interpreting the Code of Ethics in matters of professional conduct. The interpretations

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reflect the opinions, decisions, and advice of the APTA's Ethics and Judicial Committee (EJC).

The following information has been summarized from the APTA's Guide for Professional Conduct:

### **Respect**

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 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**

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 must use sound professional judgment in informing the patient/client of any substantial risks of the recommended examination and intervention and must 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 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 is 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 must establish the plan of care and must 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 must 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 must inform the patient/client and must refer the patient/client to an appropriate practitioner.

A physical therapist must 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 must 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 must avoid overutilization of physical therapy services. See Principle 8C.

### **Supervision**

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.

### **Integrity in Relationships**

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**

When considering the application of "when appropriate" under Principle 4C, it is important to know 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.

### **Exploitation**

Principle 4E is fairly clear – sexual relationships with patients/clients, supervisees or students are prohibited.

### **Colleague Impairment**

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.

### **Professional Competence**

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.

### **Professional Growth**

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 provides that the physical therapist must make sure that the process of documentation and coding accurately captures the charges for services performed.

### **Pro Bono Services**

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.

## **Standards of Ethical Conduct for the Physical Therapist Assistant**

### **Standards**

#### ***Standard #1:***

*Physical therapist assistants shall respect the inherent dignity, and rights, of all individuals.*

1A. Physical therapist assistants 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 therapist assistants shall recognize their personal biases and shall not discriminate against others in the provision of physical therapy services.

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**Standard #2:**

*Physical therapist assistants shall be trustworthy and compassionate in addressing the rights and needs of patients/clients.*

2A. Physical therapist assistants shall act in the best interests of patients/clients over the interests of the physical therapist assistant.

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

2C. Physical therapist assistants shall provide patients/clients with information regarding the interventions they provide.

2D. Physical therapist assistants shall protect confidential patient/ client information and, in collaboration with the physical therapist, may disclose confidential information to appropriate authorities only when allowed or as required by law.

**Standard #3:**

*Physical therapist assistants shall make sound decisions in collaboration with the physical therapist and within the boundaries established by laws and regulations.*

3A. Physical therapist assistants shall make objective decisions in the patient's/client's best interest in all practice settings.

3B. Physical therapist assistants shall be guided by information about best practice regarding physical therapy interventions.

3C. Physical therapist assistants shall make decisions based upon their level of competence and consistent with patient/client values.

3D. Physical therapist assistants shall not engage in conflicts of interest that interfere with making sound decisions.

3E. Physical therapist assistants shall provide physical therapy services under the direction and supervision of a physical therapist and shall communicate with the physical therapist when patient/client status requires modifications to the established plan of care.

**Standard #4:**

*Physical therapist assistants shall demonstrate integrity in their relationships with patients/ clients, families, colleagues, students, other health care providers, employers, payers, and the public.*

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

4B. Physical therapist assistants 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 therapist assistants shall not engage in any sexual relationship with any of their patients and clients, supervisees, or students.

4D. Physical therapist assistants shall not harass anyone verbally, physically, emotionally, or sexually.

4E. Physical therapist assistants shall discourage misconduct by physical therapists, physical therapist assistants, and other health care professionals and, when appropriate, report illegal or unethical acts, including verbal, physical, emotional, or sexual harassment, to an appropriate authority with jurisdiction over the conduct.

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

**Standard #5:**

*Physical therapist assistants shall fulfill their legal and ethical obligations.*

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

5B. Physical therapist assistants shall support the supervisory role of the physical therapist to ensure quality care and promote patient/client safety.

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

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

5E. Physical therapist assistants 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.

**Standard #6:**

*Physical therapist assistants shall enhance their competence through the lifelong acquisition and refinement of knowledge, skills, and abilities.*

6A. Physical therapist assistants shall achieve and maintain clinical competence.

6B. Physical therapist assistants shall engage in lifelong learning consistent with changes in their roles and responsibilities and advances in the practice of physical therapy.

6C. Physical therapist assistants shall support practice environments that support career development and lifelong learning.

**Standard #7:**

*Physical therapist assistants shall support organizational behaviors and business practices that benefit patients/clients and society.*

7A. Physical therapist assistants shall promote work environments that support ethical and accountable decision-making.

- 7B. Physical therapist assistants shall not accept gifts or other considerations that influence or give an appearance of influencing their decisions.
- 7C. Physical therapist assistants shall fully disclose any financial interest they have in products or services that they recommend to patients/clients.
- 7D. Physical therapist assistants shall ensure that documentation for their interventions accurately reflects the nature and extent of the services provided.
- 7E. Physical therapist assistants shall refrain from employment arrangements, or other arrangements, that prevent physical therapist assistants from fulfilling ethical obligations to patients/clients.

**Standard #8:**

*Physical therapist assistants shall participate in efforts to meet the health needs of people locally, nationally, or globally.*

- 8A. Physical therapist assistants shall support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.
- 8B. Physical therapist assistants shall advocate for people with impairments, activity limitations, participation restrictions, and disabilities in order to promote their participation in community and society.
- 8C. Physical therapist assistants shall be responsible stewards of health care resources by collaborating with physical therapists in order to avoid overutilization or underutilization of physical therapy services.
- 8D. Physical therapist assistants shall educate members of the public about the benefits of physical therapy.

**APTA Guide for Conduct of the Physical Therapist Assistant**

The following abridged information has been summarized from the APTA's Guide for Conduct of the Physical Therapist Assistant:

**Sound Decisions**

To fulfill 3C, the physical therapist assistant must be knowledgeable about his or her legal scope of work as well as level of competence. As a physical therapist assistant gains experience and additional knowledge, there may be areas of physical therapy interventions in which he or she displays advanced skills. At the same time, other previously gained knowledge and skill may be lost due to lack of use. To make sound decisions, the physical therapist assistant must be able to self-reflect on his or her current level of competence.

**Supervision**

Standard 3E goes beyond simply stating that the physical therapist assistant operates under the supervision of the physical therapist. Although a physical therapist retains responsibility for the patient/client throughout the episode of care, this standard requires the physical therapist assistant to take action by communicating with the supervising physical therapist when changes in the patient/client status indicate that modifications to the plan of care may be needed.

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### **Clinical Competence**

6A should cause physical therapist assistants to reflect on their current level of clinical competence, to identify and address gaps in clinical competence, and to commit to the maintenance of clinical competence throughout their career. The supervising physical therapist can be a valuable partner in identifying areas of knowledge and skill that the physical therapist assistant needs for clinical competence and to meet the needs of the individual physical therapist, which may vary according to areas of interest and expertise. Further, the physical therapist assistant may request that the physical therapist serve as a mentor to assist him or her in acquiring the needed knowledge and skills.

### **Documenting Interventions**

7D addresses the need for physical therapist assistants to make sure that they thoroughly and accurately document the interventions they provide to patients/clients and document related data collected from the patient/client. The focus of this Standard is on ensuring documentation of the services rendered, including the nature and extent of such services.

## **Informed Consent**

Patients have a fundamental right to direct what happens to their bodies, grounded in the principles of autonomy and respect for persons. In turn, health care professionals have an ethical obligation to involve patients in a process of shared decision making and to seek patients' informed consent for treatments and procedures. Good informed consent practices, thus, are an essential component of ethics quality in health care. And that means more than getting a patient's signature on a consent form.

The goal of the informed consent process is to ensure that patients have an opportunity to be informed participants in decisions about their health care. To achieve that goal practitioners must inform the patient (or authorized surrogate) about treatment options and alternatives, including the risks and benefits of each, providing the information that a "reasonable person" in similar circumstances would want to know in making the treatment decision. A key element of the process is that the practitioner must explain why he or she believes recommended treatments or procedures will be more beneficial than alternatives in the context of the patient's diagnosis.

Informed consent must always be specific: to the individual patient, the clinical situation, and the recommended plan of care or recommended treatment(s) or procedure(s).

### **Consent for Multiple Treatments**

Although consent is always specific, it is not the same as saying that separate consent is always required for every episode of repeated treatment. When the

plan of care for a given diagnosis involves repeated treatments or procedures—for example, a course of diagnostic tests or ongoing therapy—practitioners do not need to obtain consent for each individual episode.

### **Blanket Consent**

Informed consent for a planned course of multiple repeated treatments based on a specific diagnosis is very different from practices sometimes referred to as “routine” or “blanket” consent. Asking a patient to agree at the outset of care to “any treatment your doctors think is necessary,” or “routine procedures as needed,” is ethically problematic in several ways. Such practices fail to meet the requirement that consent be specific.

Moreover, seeking consent “in case” a patient should need some future intervention that is not related to that patient’s current clinical status violates the fundamental ethical norm that patients must make decisions about proposed treatments or procedures in the context of their present situation. As a “patient-centered action,” informed consent involves the contemporaneous bodily integrity, rights, dignity, intelligence, preferences, interests, goals, and welfare. If a patient’s condition changes enough to warrant a change in the plan of care, the practitioner must explain to the patient (or authorized surrogate) how the situation has changed, establish goals of care in light of the new situation, recommend a new plan of care, and obtain informed consent for the new plan or for specific treatment(s) or procedure(s) now recommended.

### **Notification versus Consent**

Informed consent is also different from “notification,” that is, providing general information relevant to patients’ participation in health care. Notification informs patients not only about their rights, but also about organizational activities and processes that shape how care is delivered. Like informed consent, notification serves the goal of respecting patients as moral agents.

### **Refusing Treatment**

The right to refuse unwanted treatment, even potentially life-saving treatment, is central to health care ethics. Health care professionals are understandably concerned when patients refuse recommended treatments. How should practitioners respond when a patient declines an intervention that practitioners believe is appropriate and needed? The answer to that question depends on both the patient’s decision-making capacity and the particular circumstances of the treatment decision.

Practitioners should take care not to assume that a patient who refuses recommended treatment lacks decision-making capacity. A capacity assessment is appropriate if the practitioner has reason to believe the patient might lack one or more of the components of decision-making capacity. When decision-making capacity is not in question, practitioners must respect the patient’s decision to

decline an intervention, even if they believe the decision is not the best one that could have been made. However, this does not mean that health care professionals should never question the patient's decision, or never try to persuade the patient to accept treatment. For example, by exploring the reasons for refusal with the patient, a practitioner might learn that the patient simply needs more information before deciding to proceed.

The professional ethical ideal of shared decision-making calls for active, respectful engagement with the patient or surrogate. As a prelude to exploring a patient's refusal of recommended treatment, practitioners should clarify the patient's (and/or surrogate's) understanding of the clinical situation and elicit his or her expectations about the course of illness and care. Practitioners should clarify the goals of care with the patient or surrogate, address expectations for care that may be unrealistic, and work with the patient or surrogate to prioritize identified goals as the foundation for a plan of care.

Asking in a nonjudgmental way, "What leads you to this conclusion?" can then help the practitioner to understand the reasons for the patient's decision to decline recommended treatment. It can also help to identify concerns or fears the patient may have about the specific treatment that practitioners can address. The aim should be to negotiate a plan of care that promotes agreed on goals of care.

### **Resisting Treatment**

Health care professionals face different concerns when patients who lack decision-making capacity resist treatment for which their authorized surrogates have given consent. When a surrogate consents to treatment on behalf of a patient who lacks decision-making capacity, practitioners are authorized to carry out the treatment or procedure even if the patient actively resists. In such cases, treatment is not being administered over the patient's refusal because the surrogate has taken the patient's place in the process of shared decision making and exercised the patient's decision-making rights. However, practitioners should still be sensitive to patients who resist treatment. They should try to understand the patient's actions and their implications for treatment. Practitioners should ask themselves why, for example, a patient repeatedly tries to pull out a feeding tube. Is the tube causing physical discomfort? Is the patient distressed because he or she does not understand what is happening?

Resistance to treatment should prompt practitioners to reflect on whether the treatment is truly necessary in light of the established goals of care for the patient, or whether it could be modified to minimize the discomfort or distress it causes. For instance, a patient may resist treatment via one route of administration but not another.

Practitioners should also be alert to the implications of the patient's resistance for the judgment that he or she lacks decision-making capacity. In some cases,

resistance to treatment may be an expression of the patient's authentic wishes. Decision-making capacity is not an "all or nothing" proposition. Rather, decision-making capacity is task specific. It rests on being able to receive, evaluate, deliberate about and manipulate information, and communicate a decision, which can vary considerably with the decision to be made. A patient may have capacity to make a simple decision but not a more complex one.

When a patient resists, surrogates, family members, or friends may be able to shed light on the patient's actions and help practitioners identify ways to provide treatment that are less upsetting for the patient. For patients with fluctuating capacity, it may be possible to explore concerns directly with the patient during lucid moments.

Patients who resist treatment present unique challenges for health care practitioners. The root cause of the resistance should be explored, as well as other clinically acceptable alternatives to the proposed treatment.

## **Relationships**

Boundaries define the limits of appropriate behavior by a professional toward his or her clients. By establishing boundaries, a health care professional creates a safe space for the therapeutic relationship to occur. Health care professionals need guidance if they are to avoid engaging in interactions with their patients that may prove ethically problematic.

### **Professionalism**

The notion of boundaries in the health care setting is rooted in the concept of a "profession". While this concept is understood in several different ways in the medical and sociological literature, there is consensus regarding one of the defining characteristics of professions and professionals: commitment to serve the profession's clients. That is, professionals are expected to make a fiduciary commitment to place their clients' interests ahead of their own. In exchange for faithfully applying their unique knowledge and skills on behalf of their clients, members of a profession are granted the freedom to practice and to regulate themselves.

Patients who come to health care professionals when they are ill and vulnerable bring with them expectations about this interaction and how clinicians should behave toward them as health care professionals, though patients are not always able to articulate those expectations clearly. Patients should be able to trust that their interests and welfare will be placed above those of the health care professional, just as they should be confident they will be treated with respect, and be informed so that they can make their own health care decisions to the greatest extent possible. Professionals, as such, are held to different standards

of conduct from other persons. Relationships and interactions that may be ethically unproblematic among nonprofessionals may be unacceptable when one of the parties is a professional. An individual may have a personal interest that is perfectly acceptable in itself, but conflicts with an obligation the same individual has as a health care professional.

For example, under circumstances in which it would normally be acceptable for one person to ask another individual for a date, it may not be acceptable for a health care professional to ask a patient for a date, because doing so might compromise the professional's fiduciary commitment to the patient's welfare. The nature of professions is such that the human needs the professions address and the human relationships peculiar to them are sufficiently distinct to warrant, indeed, to demand, expectations of a higher morality and a greater commitment to the good of others than in most other human activities.

### **Boundaries**

Boundaries define the professional relationship as fundamentally respectful and protective of the patient and as dedicated to the patient's well-being and best interests. A boundary violation occurs when a health care professional's behavior goes beyond appropriate professional limits. Boundary violations generally arise when the interaction between parties blurs their roles vis-à-vis one another. This creates what is known as a "double bind situation". That is a circumstance in which a personal interest displaces the professional's primary commitment to the patient's welfare in ways that harm—or appear to harm—the patient or the patient-clinician relationship, or might reasonably be expected to do so.

### **Legal Aspects**

Various legal and regulatory requirements address boundaries in patient-professional interactions. Clinicians are subject to guidelines for professional conduct in health care promulgated by state licensing boards. Most state professional licensing boards have addressed specific boundary issues. For example, "engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual ... [or] behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient."

Some state board guidelines offer specific guidance to help clinicians avoid inappropriate conduct, such as recommending that professionals restrict contact with patients to appropriate times and places for the therapy to be given. Violations of these guidelines could result in probation, limitation of practice, and suspension or revocation of licensure. Clinicians should be aware; moreover, that inappropriate sexual or physical contact can result in patients suing clinicians for battery and malpractice, and in several states sexual exploitation of a patient is considered a felony.

### **Other Problematic Relationships**

Many kinds of interaction potentially interfere with the primary clinical relationship between practitioner and patient and pose concerns about acceptable conduct for health care professionals. Becoming socially involved or entering into a business relationship with a patient, for example, can impair, or appear to impair, the professional's objectivity. Accepting a gift is sometimes an appropriate way to allow a patient to express his or her gratitude, and at other times is problematic. Showing favoritism—by giving a particular patient extra attention, time, or priority in scheduling appointments, for example—can cross the boundary between action that is appropriate advocacy on behalf of a particular patient and action that is unfair to others.

Such interactions or activities are ethically problematic when they can reasonably be expected to affect the care received by the individual or by other patients or the practitioner's relationships with his or her colleagues, or when they give the appearance of doing so. Yet not all behavior that might be considered inappropriate necessarily violates professional obligations.

Health care professionals should be alert to situations in which they may be likely to be motivated to behave in ways that violate accepted ethical standards. Ambiguous interactions and relationships, for example, have the potential both to impair the professional's objectivity and compromise his or her judgment, and to give rise to conflicting expectations on the patient's part, which can contaminate the therapeutic relationship and potentially undermine the patient's trust.

### **Gifts and Conflict of Interest**

Because gifts create relationships, health care professionals' acceptance of gifts from commercial vendors can be ethically problematic in several ways. Accepting gifts risks undermining trust. It may bias clinicians' judgments about the relative merits of different treatments. And it may affect treatment patterns in ways that increase costs and adversely affect access to care.

Health care professionals' fiduciary, or trust-based, relationship with patients requires that practitioners explain the reasons for treatment decisions and disclose any potential conflicts of interest, including the influence of gifts.

Given the ways in which gift giving differs from entering into a contractual relationship, gifts to health care professionals can blur the distinction between formal business exchanges and informal, interpersonal exchanges. Industry gifts to health care professionals create potential conflicts of interest that can affect practitioners' judgment—without their knowledge and even contrary to their intent—thereby placing professional objectivity at risk and possibly compromising patient care.

If accepting gifts is ethically problematic in these ways, why do health care professionals continue to take the gifts they are offered? One explanation is that accepting a gift is a natural, socially expected reaction motivated by a combination of self-interest and politeness. But it is also argued that health care professionals have come to expect gifts as part of a “culture of entitlement” that has evolved over many years. Gifts have become a familiar part of many health care workplace cultures and established patterns of behavior often resist change. Other rationales are that inducements such as free lunches are needed to induce attendance at educational sessions (and may help offset the costs of such programs), and that they help boost employee morale. Some even claim that accepting gifts results in economic savings for health care institutions, because the industry provides for free items that the institutions would otherwise have to buy. Finally, apathy on the part of professional bodies allows the “tradition” of accepting gifts to continue.

Failure to enforce ethical standards consistently has made it easier simply not to notice, or not to be concerned about, the fact that accepting gifts creates ethical risks. None of these arguments, however, is compelling enough to allow an ethically problematic practice to continue. While habit and self-interest can be powerful motivators, ethical standards explicitly require health care professionals to place patient interests above their own.

In recent years, many prominent organizations and associations have established ethical guidelines for health care professionals about accepting gifts from industry representatives. These guidelines do not prohibit all gifts from industry, but there is general agreement that gifts from companies to health care professionals are acceptable only when the primary purpose is the enhancement of patient care and medical knowledge. The acceptance of individual gifts, hospitality, trips, and subsidies of all types from industry by an individual is strongly discouraged. Practitioners should not accept gifts, hospitality, services, and subsidies from industry if acceptance might diminish, or appear to others to diminish, the objectivity of professional judgment.

Professional guidelines seek to establish thresholds for what kinds of gifts and gift relationships are acceptable. In general, gifts to individual practitioners are discouraged unless they are of minimal value and related to the practitioner’s work—such as pads, pens, or calendars for office use.

The social dynamics of the gift relationship, the potential for gifts subtly to bias health care professionals’ prescribing practices and clinical decisions, and the obligation of health care professionals to avoid acting in ways that might undermine public trust all argue for the adoption of clear, robust policies regarding the acceptance of gifts from companies. Creating a workplace in which professionals no longer routinely expect or accept gifts from industry is a

challenging task that calls for professional role modeling and sustained, coordinated efforts on the part of clinical and administrative leaders, as well as development and careful implementation of clear, well-considered policy.

### **Confidentiality**

The obligation to ensure patient privacy is rooted in the ethical principle of respect for persons. Health care providers convey that respect in a few ways with regard to privacy. They respect patient's informational privacy by limiting access to patient information to those authorized health care providers who need it to perform their duties. The obligation to ensure patient privacy is also justified by the obligation of harm prevention. Sometimes maintaining patient privacy is a way of keeping the patient safe, for example, by minimizing the risk of identity theft.

Confidentiality is mandated by HIPAA laws, specifically the Privacy Rule. The Privacy Rule protects all individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.

“Individually identifiable health information” is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.

Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

Health care providers must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request. They must also develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use, disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose.



## Indiana Code §25-27-1

The following is an abridged version of Indiana Code 25-27-1.  
If you would like to read the statute in its entirety, please go to: <https://iga.in.gov/laws/2023/ic/titles/25/#25-27-1-5>

### IC 25-27-1-1 Definitions

Sec. 1. For the purposes of this chapter:

(1) "Physical therapy" means the care and services provided by or under the direction and supervision of a physical therapist that includes any of the following:

(A) Examining, evaluating, and conduct testing on patients with mechanical, physiological, or developmental impairments, functional limitations, and disabilities or other health and movement related conditions in order to determine a physical therapy diagnosis.

(B) Alleviating impairments, functional limitations, and disabilities by designing, implementing, and modifying treatment interventions that may include therapeutic exercise, functional training in home, community, or work integration or reintegration that is related to physical movement and mobility, manual therapy, including soft tissue and joint mobilization or manipulation, therapeutic massage, prescription, application, and fabrication of assistive, adaptive, orthotic, protective, and supportive devices and equipment, including prescription and application of prosthetic devices and equipment, airway clearance techniques, integumentary protection and repair techniques, debridement and wound care, physical agents or modalities, mechanical and electrotherapeutic modalities, and patient related instruction.

(C) Using solid filiform needles to treat neuromusculoskeletal pain and dysfunction (dry needling), after completing board approved continuing education and complying with applicable board rules. However, a physical therapist may not engage in the practice of acupuncture unless the physical therapist is licensed under IC 25-2.5.

(D) Reducing the risk of injury, impairment, functional limitation, and disability, including the promotion and maintenance of fitness, health, and wellness in populations of all ages.

(E) Engaging in administration, consultation, education, and research.

(2) "Physical therapist" means a person who is licensed under this chapter to practice physical therapy.

(3) "Physical therapist assistant" means a person who:

(A) is certified under this chapter; and

(B) assists a physical therapist in selected components of physical therapy treatment interventions.

(4) "Board" refers to the Indiana board of physical therapy.

(5) "Physical therapy aide" means support personnel who perform designated tasks related to the operation of physical therapy services.

(6) "Person" means an individual.

(7) "Sharp debridement" means the removal of foreign material or dead tissue from or around a wound, without anesthesia and with generally no bleeding, through the use of:

- (A) a sterile scalpel;
- (B) scissors;
- (C) forceps;
- (D) tweezers; or
- (E) other sharp medical instruments; in order to expose healthy tissue, prevent infection, and promote healing.

(8) "Spinal manipulation" means a method of skillful and beneficial treatment by which a physical therapist uses direct thrust to move a joint of the patient's spine beyond its normal range of motion, but without exceeding the limits of anatomical integrity.

(9) "Tasks" means activities that do not require the clinical decision making of a physical therapist or the clinical problem solving of a physical therapist assistant.

(10) "Competence" is the application of knowledge, skills, and behaviors required to function effectively, safely, ethically, and legally within the context of the patient's role and environment.

(11) "Continuing competence" is the process of maintaining and documenting competence through ongoing self-assessment, development, and implementation of a personal learning plan and subsequent reassessment.

(12) "State" means a state, territory, or possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.

(13) "Direct supervision" means that a physical therapist or physical therapist assistant is physically present and immediately available to direct and supervise tasks that are related to patient management.

(14) "General supervision" means supervision provided by a physical therapist who is available by telecommunication.

(15) "Onsite supervision" means supervision provided by a physical therapist who is continuously onsite and present in the department or facility where services are provided. The supervising therapist must be immediately available to the person being supervised and maintain continued involvement in the necessary aspects of patient care.

(16) "Conduct testing" means standard methods and techniques used to gather data about a patient, including, subject to section 2.5(c) of this chapter, electrodiagnostic and electrophysiologic tests and measures. The term does not include x-rays.

(17) "Physical therapy diagnosis" means a systematic examination, evaluation, and testing process that culminates in identifying the dysfunction toward which physical therapy treatment will be directed. The term does not include a medical diagnosis.

### **IC 25-27-1-2 Unlawful practices**

(a) Except as otherwise provided in this chapter and IC 25-27-2, it is unlawful for a person or business entity to do the following:

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- (1) Practice physical therapy without first obtaining from the board a license authorizing the person to practice physical therapy in this state.
  - (2) Profess to be or promote an employee to be a physical therapist, physiotherapist, doctor of physiotherapy, doctor of physical therapy, or registered physical therapist or to use the initials "P.T.", "D.P.T.", "L.P.T.", or "R.P.T.", or any other letters, words, abbreviations, or insignia indicating that physical therapy is provided by a physical therapist, unless physical therapy is provided by or under the direction of a physical therapist.
  - (3) Advertise services for physical therapy or physiotherapy services, unless the individual performing those services is a physical therapist.
- (b) Except as provided in subsection (e) and section 2.5 of this chapter, it is unlawful for a person to practice physical therapy other than upon the order or referral of a physician, a podiatrist, a psychologist, a chiropractor, a dentist, an advanced practice registered nurse, or a physician assistant holding an unlimited license to practice medicine, podiatric medicine, psychology, chiropractic, dentistry, nursing, or as a physician assistant, respectively. It is unlawful for a physical therapist to use the services of a physical therapist assistant except as provided under this chapter. For the purposes of this subsection, the function of:
- (1) teaching;
  - (2) doing research;
  - (3) providing advisory services; or
  - (4) conducting seminars on physical therapy; is not considered to be a practice of physical therapy.
- (c) Except as otherwise provided in this chapter and IC 25-27-2, it is unlawful for a person to profess to be or act as a physical therapist assistant or to use the initials "P.T.A." or any other letters, words, abbreviations, or insignia indicating that the person is a physical therapist assistant without first obtaining from the board a certificate authorizing the person to act as a physical therapist assistant. It is unlawful for the person to act as a physical therapist assistant other than under the general supervision of a licensed physical therapist who is in responsible charge of a patient. However, nothing in this chapter prohibits a person licensed or registered in this state under another law from engaging in the practice for which the person is licensed or registered. These exempted persons include persons engaged in the practice of osteopathic medicine, chiropractic, or podiatric medicine.
- (d) Except as provided in section 2.5 of this chapter, this chapter does not authorize a person who is licensed as a physical therapist or certified as a physical therapist assistant to:
- (1) evaluate any physical disability or mental disorder except upon the order or referral of a physician, a podiatrist, a psychologist, a chiropractor, a physician assistant, an advanced practice registered nurse, or a dentist;
  - (2) practice medicine, surgery, dentistry, optometry, osteopathic medicine, psychology, chiropractic, or podiatric medicine; or
  - (3) prescribe a drug or other remedial substance used in medicine.

- (e) Upon the referral of a licensed school psychologist, a physical therapist who is:
- (1) licensed under this article; and
  - (2) an employee or contractor of a school corporation; may provide mandated school services to a student that are within the physical therapist's scope of practice.

**IC 25-27-1-2.5 Evaluations and treatment without a referral; exceptions**

- (a) Except as provided in subsection (b), a physical therapist may evaluate and treat an individual during a period not to exceed forty-two calendar days beginning with the date of the initiation of treatment without a referral from a provider described in section 2(b) of this chapter. However, if the individual needs additional treatment from the physical therapist after forty-two calendar days, the physical therapist shall obtain a referral from the individual's provider, as described in section 2(b) of this chapter.
- (b) A physical therapist may not perform spinal manipulation of the spinal column or the vertebral column unless:
- (1) the physical therapist is acting on the order or referral of a physician, an osteopathic physician, or a chiropractor; and
  - (2) the referring physician, osteopathic physician, or chiropractor has examined the patient before issuing the order or referral.
- (c) A physical therapist who conducts testing using electrophysiologic or electrodiagnostic testing must obtain and maintain the American Board of Physical Therapy Specialties Clinical Electrophysiologic Specialist Certification.

**IC 25-27-1-3.1 Practice of certain occupations or professions and first aid not prohibited**

This chapter does not prohibit any of the following:

- (1) The practice of any occupation or profession for which a person is licensed, certified, or registered in Indiana by a state agency. The persons who are exempted by this subdivision include persons licensed, certified, or registered to practice osteopathic medicine, chiropractic, or podiatric medicine.
- (2) The practice of any health care occupation or profession by a person who is practicing within the scope of the person's education and experience.
- (3) The performance of any first aid procedure incidental to a person's employment or volunteer duties.
- (4) The performance of an emergency first aid procedure by any person.
- (5) Except as provided in section 2(a)(3) of this chapter, the provision of the following by a chiropractor licensed under IC 25-10:
  - (A) Physical therapy modality services.
  - (B) Physical rehabilitation services.
  - (C) Therapeutic procedures.
  - (D) Tests and measurements.
  - (E) Therapeutic devices.
  - (F) Physiotherapy, as included in the chiropractic licensure examination.

### **IC 25-27-1-3.3 Exempt persons**

The following persons are exempt from the licensure or certification requirements of this article:

(1) A person in an entry level professional education program approved by the board who is satisfying supervised clinical education requirements related to the person's physical therapist education while under onsite supervision of a physical therapist.

(2) A physical therapist who is practicing in the armed forces of the United States, United States Public Health Service, or United States Department of Veterans Affairs under federal regulations for jurisdiction licensure of health care providers. However, if the person, while federally employed as a physical therapist, engages in the practice of physical therapy outside the course and scope of federal employment, the person must obtain a license under this chapter.

(3) A physical therapist who is licensed in another state or credentialed to practice physical therapy in another country, if the person is teaching, demonstrating, or providing physical therapy services in connection with an educational seminar. However, the exemption under this subdivision may not exceed sixty (60) days in a calendar year.

(4) A physical therapist who is licensed in another state or credentialed in another country if the person by contract or employment is providing physical therapy to patients affiliated with or employed by established athletic teams, athletic organizations, or performing arts companies temporarily practicing, competing, or performing in Indiana. However, the exemption under this subdivision may not exceed sixty (60) days in a calendar year.

(5) A physical therapist who is licensed in another state and who provides physical therapy during a declared local or national disaster or emergency. However, the exemption may not exceed sixty (60) days following the declaration of the emergency. To be eligible for the exemption the physical therapist must notify the board of the person's intent to practice.

(6) A physical therapist licensed in another state who is forced to leave the person's residence or place of employment due to a declared local or national disaster or emergency and due to the displacement seeks to practice physical therapy. However, the exemption may not exceed sixty (60) days following the declaration of the emergency. To be eligible for the exemption the physical therapist must notify the board of the person's intent to practice.

### **IC 25-27-1-3.5 Sharp debridement referral**

Sec. 3.5. A physical therapist may not perform sharp debridement unless the physical therapist is acting on the order or referral of a:

- (1) physician or osteopath
- (2) podiatrist

**IC 25-27-1-4 Indiana Board of Physical Therapy**

- (a) There is created the Indiana board of physical therapy. The board is comprised of the following:
- (1) Three (3) physical therapists.
  - (2) One (1) physical therapist assistant.
  - (3) One (1) member who is a resident of the state and who is not associated with physical therapy in any way, other than as a consumer.
- (d) Each physical therapist and physical therapist assistant appointed must:
- (1) have an unrestricted license or certificate issued under this chapter;
  - (2) have had not less than five (5) years experience in the actual practice of physical therapy immediately preceding appointment; and
  - (3) be a resident of the state and actively engaged in this state in the practice of physical therapy during incumbency as a member of the board.
- (e) The affirmative vote of a majority of the members appointed to the board is required for the board to take action on any measure.
- (f) The board shall meet at least quarterly.
- (g) A member may be removed under IC 25-1-6.5-4.

**IC 25-27-1-13 Physical therapist duties; supervision**

- (a) A physical therapist is responsible for managing all aspects of the physical therapy care of each patient. A physical therapist shall provide the following:
- (1) The initial evaluation, determination of a physical therapy diagnosis, prognosis, and plan of treatment intervention and documentation of each encounter with each patient.
  - (2) Periodic reevaluation and documentation of each patient.
  - (3) The documented discharge of the patient, including the patient's response to treatment intervention at the time of discharge.
- (b) A physical therapist shall assure the qualifications of all physical therapist assistants and physical therapy aides under the physical therapist's direction and supervision.
- (c) For each patient on each date of service, a physical therapist shall:
- (1) provide all of the treatment intervention that requires the education, skills, and knowledge of a physical therapist; and
  - (2) determine the use of physical therapist assistants to ensure that the delivery of care is safe, effective, and efficient.
- (d) A physical therapist assistant shall work under a physical therapist's supervision. A physical therapist assistant shall document the care that the physical therapist assistant provides.
- (e) A physical therapist may use physical therapy aides for designated tasks. A physical therapy aide shall work under the direct supervision of a physical therapist. Tasks related to patient services must be assigned to a physical therapy aide by a physical therapist or physical therapist assistant.

**IC 25-27-1-18 License and certificate display and verification**

Each physical therapist and physical therapist assistant shall:

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- (1) conspicuously display a copy of the license or certificate in a location accessible to public view;
- (2) immediately produce a copy of the license or certificate upon request; or
- (3) notify a patient how the patient may verify the therapist's license or certificate online.

#### **IC 25-27-2-1 Purpose and objectives**

The purpose of this Compact is to facilitate interstate practice of physical therapy with the goal of improving public access to physical therapy services. The practice of physical therapy occurs in the state where the patient or client is located at the time of the patient or client encounter. The Compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

This Compact is designed to achieve the following objectives:

- (1) Increase public access to physical therapy services by providing for the mutual recognition of other member state licenses;
- (2) Enhance the states' ability to protect the public's health and safety;
- (3) Encourage the cooperation of member states in regulating multi-state physical therapy practice;
- (4) Support spouses of relocating military members;
- (5) Enhance the exchange of licensure, investigative, and disciplinary information between member states; and
- (6) Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards.

#### **IC 25-27-2-4 Compact privilege**

(a) To exercise the compact privilege under the terms and provisions of the Compact, the licensee shall:

- (1) hold a license in the home state;
- (2) have no encumbrance on any state license;
- (3) be eligible for a compact privilege in any member state in accordance with subsections (d), (g), and (h);
- (4) have not had any adverse action against any license or compact privilege within the previous two (2) years;
- (5) notify the Commission that the licensee is seeking the compact privilege within a remote state(s);
- (6) pay any applicable fees, including any state fee, for the compact privilege;
- (7) meet any jurisprudence requirements established by the remote state(s) in which the licensee is seeking a compact privilege; and
- (8) report to the Commission adverse action taken by any non-member state within thirty (30) days from the date the adverse action is taken.

(b) The compact privilege is valid until the expiration date of the home license. The licensee must comply with the requirements of subsection (a) to maintain the compact privilege in the remote state.

- (c) A licensee providing physical therapy in a remote state under the compact privilege shall function within the laws and regulations of the remote state.
- (d) A licensee providing physical therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, and take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege in any state until the specific time for removal has passed and all fines are paid.
- (e) If a home state license is encumbered, the licensee shall lose the compact privilege in any remote state until the following occur:
  - (1) the home state license is no longer encumbered; and
  - (2) two (2) years have elapsed from the date of the adverse action.
- (f) Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection (a) to obtain a compact privilege in any remote state.
- (g) If a licensee's compact privilege in any remote state is removed, the individual shall lose the compact privilege in any remote state until the following occur:
  - (1) the specific period of time for which the compact privilege was removed has ended;
  - (2) all fines have been paid; and
  - (3) two years have elapsed from the date of the adverse action.
- (h) Once the requirements of subsection (g) have been met, the licensee must meet the requirements in subsection (a) of this chapter to obtain a compact privilege in a remote state.

**IC 25-27-2-6 Adverse actions**

- (a) A home state shall have exclusive power to impose adverse action against a license issued by the home state.
- (b) A home state may take adverse action based on the investigative information of a remote state, so long as the home state follows its own procedures for imposing adverse action.
- (c) Nothing in this Compact shall override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the member state's laws. Member states must require licensees who enter any alternative programs in lieu of discipline to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.
- (d) Any member state may investigate actual or alleged violations of the statutes and rules authorizing the practice of physical therapy in any other member state in which a physical therapist or physical therapist assistant holds a license or compact privilege.
- (e) A remote state shall have the authority to:



- (1) take adverse actions as set forth in section 4(d) of this chapter against a licensee's compact privilege in the state;
  - (2) issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a physical therapy licensing board in a party state for the attendance and testimony of witnesses, and the production of evidence from another party state, shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and evidence are located; and
  - (3) if otherwise permitted by state law, recover from the licensee the costs of investigations and disposition of cases resulting from any adverse action taken against that licensee.
- (f) Joint Investigations
- (1) In addition to the authority granted to a member state by its respective physical therapy practice act or other applicable state law, a member state may participate with other member states in joint investigations of licensees.
  - (2) Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

## **Title 842. Indiana Board of Physical Therapy**

### **Article 1. Physical Therapists and Physical Therapists' Assistants**

The following is an abridged version of Title 842 Indiana Board of Physical Therapy Rules.  
If you would like to read the statute in its entirety, please go to: [in.gov/pla/professions/physical-therapy-home/](http://in.gov/pla/professions/physical-therapy-home/)

#### **Rule 1. General Provisions 842 IAC**

##### **1-1-1 Definitions Sec. 1.**

- (a) The definitions in this section apply throughout this article.
- (b) "Agency" refers to the Indiana professional licensing agency.
- (c) "Contact hour" means a unit of measure for a continuing competency activity. One (1) contact hour equals at least fifty (50) minutes in a learning activity.
- (d) "Continuing competence" or "continuing competency" has the meaning set forth in IC 25-27-1-10(11) and IC 25-27-2-2(5). The requirements for demonstrating continuing competence are set forth in 842 IAC 1-7-1.
- (e) "Direct supervision" has the meaning set forth in IC 25-27-1-1(13).
- (f) "Physical therapist assistant" has the meaning set forth in IC 25-27-1-1(3)
- (g) "Physical therapy" has the meaning set forth in IC 25-27-1-1(1) and includes, but is not limited to, such measures as the following:
  - (1) Performing and interpreting tests and measurements of neuromuscular, musculoskeletal, cardiac, and pulmonary functions as a part of treatment, interpretation of physician referrals, initial patient evaluation, initial and ongoing

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treatment planning, periodic reevaluation of the patient, and adjustment of the treatment plan.

(2) Planning initial and subsequent treatment programs on the basis of test findings, and if the patient is referred for physical therapy, within the orders of a referring provider.

(3) Administering treatment through the use of physical, chemical, or other properties of heat or cold, light, water, electricity, massage, mechanical devices, and therapeutic exercise, which includes all types of physical rehabilitative techniques and procedures, including using solid filiform needles to treat neuromusculoskeletal pain and dysfunction (dry needling).

(h) "Referring provider" refers to an individual authorized to provide an order or referral for physical therapy under IC 25-27-1-2(b).

#### 842 IAC 1-1-2 Standards of practice for physical therapy services

(a) A physical therapy service shall be under the direction of a licensed physical therapist who is qualified by experience, demonstrated ability, and specialized education. The supervising physical therapist at all times shall be available and under all circumstances shall be responsible for the direction and the actions of the person supervised when services are performed by the physical therapist assistant, or the holder of a temporary permit issued under IC 25-27-1-8(d). For the holder of a temporary permit issued under IC 25-27-1-8(d), unless the supervising physical therapist is on the premises to provide constant supervision, the holder of a temporary permit shall meet with the physical therapist at least once each working day to review all patients' treatments. This meeting must include the actual presence of the physical therapist and the holder of a temporary permit. The patients' care shall always be the responsibility of the supervising physical therapist. Reports written by the holder of a temporary permit for inclusion in the patient record shall be countersigned by the physical therapist who may enter any remarks, revisions, or additions as the physical therapist deems appropriate. With respect to the supervision of the physical therapist assistants under IC 25-27-1-2(c), unless the supervising physical therapist is on the premises to provide constant supervision, the physical therapist assistant shall consult with the supervising physical therapist at least once each working day to review all patients' treatments. The supervising physical therapist shall examine each patient not less than:

(1) every fourteen (14) days for inpatients in either a hospital or comprehensive rehabilitation facility;

(2) the earlier of every ninety (90) days or six (6) physical therapy visits for patients in a facility for the developmentally disabled (DD) and school system patients; and

(3) the earlier of every thirty (30) days or every fifteen (15) physical therapy visits for all other patients;

to review the patients' treatments and progress. If this daily consultation is not face-to-face, the physical therapist may not supervise more than the equivalent of three (3) full-time physical therapist assistants. Consultation between a

supervising physical therapist and the physical therapist assistant may be in person, by telephone, or by a telecommunications device for the deaf (TDD), so long as there is interactive communication concerning patient care.

(b) A physical therapist shall develop a plan of care for each patient referred and shall be responsible for the plan implementation and modification. When a patient is referred for physical therapy by a referring provider, a physical therapist shall consult with the referring provider regarding any contraindicated or unjustified treatment.

(c) The physical plant shall be planned, constructed, and equipped to provide adequate space and a proper environment to meet the service needs with safety and efficiency.

(d) A physical therapist assistant may assist in the practice of physical therapy under the supervision of a licensed physical therapist by performing those assigned physical therapy procedures identified in 842 IAC 1-1-1(g)(3) with the exception of the use of solid filiform needles to treat neuromuscular pain and dysfunction (dry needling), but not those specified in subsections 842 IAC 1-1-1(g)(1) or (2)

#### **Rule 4. Registration of Licensed Physical Therapists and Physical Therapists' Assistants**

842 IAC 1-4-1 Mandatory registration;

(a) Every physical therapist holding a license issued by the board shall renew his or her license biennially on or before July 1 of each even-numbered year.

(b) A licensee's failure to receive notification of renewal due to failure to notify the committee of a change of address or name shall not constitute an error on the part of the board, or agency, nor shall it exonerate or otherwise excuse the licensee from renewing such license.

(c) Every physical therapist assistant holding a certificate issued by the board shall renew his or her certificate biennially on or before July 1 of each even-numbered year.

(d) A certificate holder's failure to receive notification of renewal due to failure to notify the board of a change of address or name shall not constitute an error on the part of the board, or agency, nor shall it exonerate or otherwise excuse the certificate holder from renewing such certificate.

#### **Rule 6. Standards of Professional Conduct**

842 IAC 1-6-1 Definitions

For purposes of the standards of professional conduct and competent practice of physical therapy or practice as a physical therapist assistant, the following definitions apply:

(1)"Practitioner" means a person holding a license to practice physical therapy; a person holding a certificate to practice as a physical therapist assistant; or a person holding a temporary permit issued by the board.

(2)"Professional incompetence" may include, but is not limited to, a pattern or course of repeated conduct by a practitioner demonstrating a failure to exercise

such reasonable care and diligence as is ordinarily exercised by practitioners in the same or similar circumstances in the same or similar locality.

842 IAC 1-6-2 Standards of professional conduct and competent practice

(a) A practitioner when engaging in the practice of physical therapy shall abide by, and comply with, the standards of professional conduct in this section.

(b) A practitioner shall maintain the confidentiality of all knowledge and information regarding a patient, including, but not limited to, the patient's:

(1) diagnosis;

(2) treatment; and

(3) prognosis; of which the practitioner has knowledge during the course of the patient-practitioner relationship.

Information about a patient shall be disclosed by a practitioner when required by law.

(c) A practitioner shall give a truthful, candid, and reasonably complete account of the patient's condition to the patient or to those responsible for the patient's care, except where a practitioner reasonably determines that the information is detrimental to the physical or mental health of: (1) the patient; or (2) those persons responsible for the patient's care.

(d) The practitioner shall give reasonable written notice to the patient and to the referring provider when the practitioner withdraws from a case so that another referral may be made by the referring provider. A practitioner shall not abandon a patient. A practitioner who withdraws from a case, except in emergency circumstances, shall, upon written request, comply with the provisions of IC 16-39-1-1 et seq., and of any subsequent amendment or revision thereof, when a patient requests health records.

(e) A practitioner shall exercise reasonable care and diligence in the treatment of patients based upon generally accepted scientific principles, methods, treatments, and current professional theory and practice.

(f) A practitioner shall not: (1) represent; (2) advertise; (3) state; or (4) indicate; the possession of any degree recognized as the basis for licensure to practice physical therapy unless the practitioner is actually licensed on the basis of such degree in the state or states in which he/she practices.

(g) A physical therapist shall not delegate to supportive personnel any service that requires the skill, knowledge, and judgment of the licensed physical therapist.

(h) A physical therapist assistant shall not accept a delegation of a service that exceeds the scope of practice of their certificate.

(i) A physical therapist must have the knowledge, skill, ability, and competence to perform dry needling. After June 30, 2024, to be deemed competent to perform dry needling, a physical therapist must successfully complete a minimum of fifty (50) hours of education specific to dry needling theory, practice, and technique of which forty (40) hours must be completed in person.

(1) A physical therapist may apply dry needling specific education hours completed within the entry-level education program toward the fifty (50) hour

requirement. The physical therapist must complete any remaining education hours to reach a total of fifty (50) hours prior to providing dry needling services.

(2) The physical therapist bears the burden of proof of sufficient education and training to ensure competence with the treatment or intervention. Education courses that meet the requirements of 842 IAC 1-7-5 satisfy this requirement.

(3) If requested by the board or a member of the public, the physical therapist providing dry needling services shall provide documentation of completion of the training required by this rule.

(4) Failure to provide written documentation to the board in compliance with this requirement shall be deemed prima facie evidence that the physical therapist is not competent and shall not be permitted to perform dry needling.

(5) Dry needling shall be performed directly by the physical therapist and shall not be delegated.

(j) A practitioner who has personal knowledge based upon a reasonable belief that another practitioner holding the same license or certificate has engaged in illegal, unlawful, incompetent, or fraudulent conduct in the practice of physical therapy shall promptly report such conduct to a peer review or similar body, having jurisdiction over the offending practitioner and the matter. This provision does not prohibit a practitioner from promptly reporting said conduct directly to the physical therapy board. Further, a practitioner who has personal knowledge of any person engaged in, or attempting to engage in, the unauthorized practice of medicine or physical therapy shall promptly report such conduct to the Indiana Board of Physical Therapy.

(k) A practitioner who voluntarily submits himself or herself to, or is otherwise undergoing a course of treatment for: (1) addiction; (2) severe dependency upon alcohol or other drugs or controlled substances; or (3) psychiatric impairment; where such treatment is sponsored or supervised by a committee for impaired practitioners of a state, regional, or local organization of professional health care providers, or where such treatment is sponsored or supervised by a committee for impaired practitioners of a hospital, shall be exempt from reporting to a peer review committee as set forth in subsection (j) or to the physical therapy board so long as the practitioner is complying with the course of treatment and making satisfactory progress. If the practitioner fails to comply with or is not benefited by the course of treatment, the practitioner-chief administrative officer, his or her designee, or any member of the committee for impaired practitioners shall promptly report such facts and circumstances to the physical therapy committee. Subsection (j) and this subsection shall not, in any manner whatsoever, directly or indirectly, be deemed or construed to prohibit, restrict, limit, or otherwise preclude the physical therapy board from taking such action as it deems appropriate or as may otherwise be provided by law.

(l) Fees charged by a practitioner for his or her professional services shall be reasonable and shall reasonably compensate the practitioner only for services actually rendered.

(m) A practitioner shall not enter into agreement for, charge, or collect an illegal or clearly excessive fee.

(n) Factors to be considered in determining the reasonableness of a fee include, but are not limited to, the following: (1) The difficulty or uniqueness, or both, of the services performed and the time, skill, and experience required. (2) The fee customarily charged in the locality for similar practitioner services. (3) The amount of the charges involved. (4) The quality of performance. (5) The nature and length of the professional relationship with the patient. (6) The experience, reputation, and ability of the practitioner in performing the kind of services involved.

(o) A practitioner shall not pay, demand, or receive compensation for referral of a patient except for a patient referral program operated by a professional society or association.

(p) A practitioner shall be responsible for the conduct of each and every person employed by the practitioner for every action or failure to act by said employee or employees in the course of the employment relationship.

(q) A practitioner shall not, on behalf of: (1) himself or herself; (2) a partner; (3) an associate; (4) a shareholder in a professional corporation; or (5) any other practitioner or specific health care provider affiliated with the practitioner; use, or participate in the use of, any form of public communication containing a false, fraudulent, misleading, deceptive, or unfair statement or claim.

(r) Subject to the requirements of subsection (q), and in order to facilitate the process of informed selection of a practitioner by the public, a practitioner may advertise services through the public media, provided that the advertisement is dignified and confines itself to the existence, scope, nature, and field of practice of physical therapy.

(s) If the advertisement in subsection (q) is communicated to the public by audio or video format, it shall be prerecorded and approved for broadcast by the practitioner, and a recording and transcript of the actual transmission shall be retained by the practitioner for a period of five (5) years from the last date of broadcast.

(t) If a practitioner advertises a fee for: (1) a service; (2) a treatment; (3) a consultation; (4) an examination; or (5) any other procedure; the practitioner must render that service or procedure for no more than the fee advertised.

(u) Except as otherwise provided in these rules, a practitioner shall not contact or solicit individual members of the public personally or through an agent in order to offer services to such person or persons unless that individual initiated contact with the practitioner for the purpose of engaging that practitioner's professional services.

(v) A practitioner may, whenever the practitioner believes it to be beneficial to the patient, and upon approval of the referring provider, send or refer a patient to a qualified specific professional health care provider for treatment or health care that falls within the specific professional health care provider's scope of practice. Prior to any such referral, however, the practitioner shall examine or consult with, or both, the patient and the referring provider to ensure that a condition exists in the patient that would be within the scope of practice of the specific professional health care provider to whom the patient is referred or sent.

(w) The practitioner shall give reasonable written notice to an active patient or those responsible for the patient's care when the practitioner withdraws from a case so that another practitioner may be employed by the patient or by those responsible for the patient's care. A practitioner shall not abandon a patient. As used in this section, "active patient" means a person whom the practitioner has examined, cared for, or otherwise consulted with, during the two (2) year period prior to retirement, discontinuation of practice, or leaving or moving from the community.

(x) A practitioner who withdraws from a case, except in emergency circumstances, shall, upon written request, make available to the license holder's patient all records, test results, histories, diagnoses, files, and information relating to said patient which are in the practitioner's custody, possession, or control, or copies of such documents herein before described.

(y) A practitioner shall not base his fee upon the uncertain outcome of a contingency, whether such contingency be the outcome of litigation or any other occurrence or condition that may or may not develop, occur, or happen.

(z) A practitioner shall not attempt to exonerate himself or herself from or limit his or her liability to a patient for his or her personal malpractice except that a practitioner may enter into agreements that contain informed, voluntary releases or waivers of liability, or both, in settlement of a claim made by a patient or by those responsible for a patient's care.

(aa) A practitioner shall not attempt to preclude, prohibit, or otherwise prevent the filing of a complaint against him or her by a patient or other practitioner for any alleged violation of this title, IC 25-27-1 et seq., or any other law.

(bb) A practitioner shall maintain adequate patient records.

(cc) A practitioner shall not interfere with, or refuse to cooperate in, an investigation or disciplinary proceeding by willful misrepresentation of facts or the use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding or any legal action.

(dd) A practitioner shall not aid or abet a person not licensed or certified in this state who directly or indirectly performs activities requiring a license or certificate.

(ee) A practitioner shall not practice as a physical therapist or work as a physical therapist assistant when physical or mental abilities are impaired by the use of: (1) controlled substances; (2) other habit-forming drugs; (3) chemicals; or (4) alcohol.

(ff) A practitioner shall not engage in the performance of substandard care due to a deliberate or negligent act or failure to act regardless of whether there was actual injury to the patient.

(gg) A practitioner shall not engage in sexual misconduct, including the following: (1) Making sexual advances. (2) Requesting sexual favors. (3) Engaging in verbal conduct or physical contact of a sexual nature with patients or clients.

(hh) A practitioner who has been convicted of a felony, or who has pled no contest or any other finding of guilt as to such felony, in this or any other state, territory, or country, which demonstrates impaired judgment or risk to the public

in the practitioner's future provision of physical therapy service, may be deemed to be in violation of this section.

(ii) Failure to comply with the above standards of professional conduct and competent practice of physical therapy may result in disciplinary proceedings against the offending practitioners. Further, all practitioners licensed in Indiana shall be responsible for having knowledge of these standards of conduct and practice.

### **Rule 7. Continuing Competency Requirements**

#### **842 IAC 1-7-1 Continuing competency requirements**

(a) Twenty-two (22) hours of continuing competency activities are required for the biennial renewal period, of which two (2) hours must be in an ethics and Indiana jurisprudence course as it relates to the practice of physical therapy.

(b) Only activities that have been approved under this article will be accepted as credit for license or certification renewal.

(c) Continuing competency hours: (1) must be obtained within the biennial renewal period; and (2) may not be carried over from one renewal period to another.

(d) If a license or certification is valid for less than twelve months, no continuing competency activity is required for renewal. If the license or certification is valid for twelve to twenty-three months, twelve hours of continuing competency activities are required for renewal, which shall include the two hours of an ethics and Indiana jurisprudence course as it relates to the practice of physical therapy.

(e) Audits for compliance with continuing competency requirements and actions regarding noncompliance will be conducted as provided for in IC 25-1-4.

#### **842 IAC 1-7-2 Responsibilities of licensees**

A license or certificate holder shall do the following:

(1) Certify completion of continuing competency activities required by this rule at the time of license or certification renewal.

(2) Retain verification of completion of continuing competency activities required by this rule for three years after the last renewal date.

(3) Present proof of completion of continuing competency activities required by this rule at the request of the board on a form that is approved by the board.

#### **842 IAC 1-7-3 License or certification period; number of hours required Authority:**

(a) During each two-year license period, a physical therapist or physical therapist's assistant must complete at least twenty-two hours of continuing competency activities of which at least ten hours must be in category I courses and two hours must be in an ethics and Indiana jurisprudence course as it relates to the practice of physical therapy.

(b) A physical therapist or physical therapist's assistant may not earn more than ten category II credit hours towards the requirements under this section.



842 IAC 1-7-4 "Category I continuing competency activities" and "category II continuing competency activities"

(a) As used in this rule, "category I continuing competency activities" includes the following and must be at least one contact hour in length and be relevant to the practice of physical therapy:

- (1) Formally organized courses.
- (2) Workshops.
- (3) Seminars.
- (4) Symposia.
- (5) Home study programs, including approved computer, audio, and video instructional programs, designed by board approved organizations and subject to board verification and approval procedures.
- (6) Approved "for credit" courses that are related to the practice of physical therapy from an approved organization as defined in IC 25-1-4-0.2.

(b) The following conversion will be used for "category I continuing competency credit":

- (1) One semester hour equals fifteen contact hours.
- (2) One quarter hour equals ten contact hours.
- (3) One trimester hour equals twelve and one-half hours.

(c) As used in this rule, "category II continuing competency activities" includes the following:

(1) Professional research/writing. A licensee or certificate holder may receive continuing competency credit for publication of scientific papers, abstracts, or review articles in peer-reviewed and other professional journals; publication of textbook chapters; and poster or platform presentations at conferences sponsored by any approved entity up to a maximum of ten hours per biennium. The following conversion will be used for continuing competency credit:

- (A) Ten hours for each refereed article.
- (B) Three hours for each nonrefereed article, abstract of published literature or book review.
- (C) Eight hours for each published textbook chapter.
- (D) Five hours for each poster or platform presentation or review article.

(2) Teaching as an adjunct responsibility at an accredited PT or PTA program. Two hours of credit for each academic credit hour awarded by the accredited PT or PTA program for the first time the course is taught up to a maximum of ten hours per biennium.

(3) Participation as a presenter in an approved workshop, continuing education course, seminar, or symposium. Two contact hours for each one hour of presentation for first event, with a maximum of ten hours per biennium.

(4) Supervision of physical therapist students or physical therapist assistant students from accredited programs in full-time clinical internships or

residency programs. One contact hour for every forty hours of supervision with a maximum of ten contact hours per biennium.

(5) In-house or in-service seminars related to the practice of physical therapy. One credit hour for each hour of in-service. Maximum of four hours per biennium. Documentation shall consist of a description of the topic, date, duration, and the name of the presenter.

(6) Actively participating with professional organizations related to the practice of physical therapy, with one credit hour for each six months service as an officer, delegate, or board member, for a maximum of six hours per biennium.

(7) Certification of clinical specialization by the American Board of Physical Therapy Specialties (ABPTS) or another organization approved by the Indiana physical therapy board: ten hours maximum per biennium. Credit may be awarded only in the year that certification or recertification is obtained.

(8) Certificate of Advanced Proficiency for the PTA by the APTA: five hours maximum per biennium to be awarded. Credit may be awarded only in the year that certification or recertification is obtained.

(9) Attendance at INAPTA state or district meetings that are at least one hour in length, for a maximum of one hour per meeting, for a maximum of four hours per biennium.

(10) Other scholarly or educational, or both, activities related to the practice or management of physical therapy and not described above, with approval from the committee.

#### 842 IAC 1-7-5 Approved organizations; standards for approval

(a) In addition to those approved organizations approved under IC 25-1-4-0.2, the following organizations are approved organizations for the purpose of approving and sponsoring continuing competency courses without making further application to the committee:

(1) American Physical Therapy Association (APTA).

(2) American Physical Therapy Association Indiana Chapter (APTA Indiana).

(3) Federation of State Boards of Physical Therapy (FSBPT).

(4) A national, state, district, or local organization that operates as an affiliated entity under the approval of any organization listed in the subdivisions (1) through (3).

(b) The board will approve continuing competency activities if it determines that the activity:

(1) contributes directly to professional competency;

(2) relates directly to the practice, management, or education of physical therapy practitioners; and

(3) is conducted by individuals who have demonstrated expertise in the subject matter of the program.

Prior approval by the board is not required for the aforementioned approved organizations. Proof of content shall be demonstrated by the original

workshop or conference brochure, agenda, or materials given to participants during the presentations and evidence of successful completion of the course provided by the course instructor, such as certificate of completion or signed agenda indicating completion.

## Case Studies

### Case Study #1 - Confidentiality

*John Jones PT, Sue Brown (therapy receptionist), and Mary Smith (Therapy managed care contracting), are in a private PT office discussing the fact that they are treating Biff Simpson, a star NFL quarterback. John says, "I can't believe that I'm actually treating Biff Simpson." Mary asks, "How bad do you think his injury is?" John replies, "I saw his MRI report, it looks like he is going to need surgery."*

*Is this a breach in confidentiality?*

The information contained in each patient's medical record must be safeguarded against disclosure or exposure to nonproprietary individuals. The right to know any medical information about another is always predicated on a sound demonstration of need. Frequently, many individuals require access to information contained in a patient's medical record. Their right to access this information is limited to only that information which is deemed necessary for them perform their job in a safe, effective, and responsible manner.

The first questions we must ask are "What information is being disclosed and do the three individuals engaged in the conversation have a need to know this information?"

John's first statement discloses the name of person receiving care, and his second statement reveals private patient medical information. Certainly, as the primary therapist, John would need to know the patient's name and therapy related diagnosis in order to provide care. Sue, the receptionist, may also need this information to schedule appointments and perform other essential clerical tasks. Mary, whose job it is to contract with managed care organizations, most likely has no compelling reason to know either the patient's identity or any of his medical information. Therefore, the disclosure to Mary of the patient's identity and medical information is a breach of patient confidentiality.

### Case Study #2 – Qualifications of Practice

*You work in very busy outpatient rehab clinic. One of your coworkers is a physical therapy aide who has worked in rehabilitation for more than 20 years.*

*Frequently, she is called upon to perform treatments that should be done by a PT or PTA. The patients always give her compliments, and frequently request her to treat them. She demonstrates exceptional skills and achieves outstanding outcomes.*

*Is the clinic providing ethical care to its patients?*

The practice of physical therapy is closely regulated throughout the United States. Each state, through legislation, establishes minimal licensure and practice standards. This is done to protect the general public against fraud and substandard care by under-qualified practitioners. It is each physical therapist's responsibility to adhere to the standards of care and licensure requirements specific to the state in which they practice. The therapist must also ensure that all care provided not directly by them, but under their supervision, also meets these standards.

In this situation, the aide's abilities and outcomes are considered irrelevant. The key sentence in the paragraph is: "perform treatments that should be done by a PT or PTA.". The "should" in this case must not be interpreted as merely a casual suggestion but rather a legal definition regulated by the state's Physical Therapy Practice Act. Any treatment or procedure that should be performed by a licensed professional must be performed by a licensed professional.

### **Case Study #3 – Informed Consent**

*Sam is a PT who has just received orders to begin ambulation with a 75-year-old woman who is s/p right hip ORIF. He goes to her hospital room to evaluate her and begin ambulation. She says she does not want therapy today because she is in too much pain. Sam explains to her that the doctor has left orders for her to begin walking. The patient refuses. Sam leaves and returns the next day to try again. Again, she declines treatment and he then leaves.*

*Under the guidelines of informed consent, were the therapist's actions adequate?*

Patients have a fundamental right to direct what happens to their bodies, grounded in the principles of autonomy and respect for persons. In turn, health care professionals have an ethical obligation to involve patients in a process of shared decision making and to seek patients' informed consent for treatments and procedures. Good informed consent practices, thus, are an essential component of ethics quality in health care. And that means more than getting a patient's signature on a consent form.

The goal of the informed consent process is to ensure that patients have an opportunity to be informed participants in decisions about their health care. To

achieve that goal practitioners must inform the patient (or authorized surrogate) about treatment options and alternatives, including the risks and benefits of each, providing the information that a “reasonable person” in similar circumstances would want to know in making the treatment decision. A key element of the process is that the practitioner must explain why he or she believes recommended treatments or procedures will be more beneficial than alternatives in the context of the patient’s specific condition.

Informed consent must always be specific: to the individual patient, the clinical situation, and the recommended plan of care or recommended treatment(s) or procedure(s).

The most important goal of informed consent is that the patient has an opportunity to be an informed participant in their health care decisions. It is generally accepted that adequate informed consent must include communication of the following:

- the nature of the decision/procedure
- reasonable alternatives to the proposed intervention
- the relevant risks, benefits, and uncertainties of each alternative
- professional recommendations specific to the individual patient
- the consequences on non-treatment
- the goals of treatment
- the prognosis for achieving the goals

In order for the patient’s consent to be valid, they must be considered competent to make the decision at hand and their consent must be voluntary. The therapist should make clear to the patient that they are participating in a decision, not merely signing a form. With this understanding, the informed consent process should be seen as an invitation for them to participate in their health care decisions. The therapist is also generally obligated to provide a recommendation and share their reasoning process with the patient. Comprehension on the part of the patient is equally as important as the information provided. Consequently, the discussion should be carried on in layperson’s terms and the patient’s understanding should be assessed along the way.

In this situation, the Sam’s actions were not sufficient. None of the required information was offered to the patient. The most important thing the therapist failed to explain to the patient was the consequences of non-treatment. The patient cannot make an informed decision regarding therapy without this information. It could be argued that her decision to refuse therapy may have changed had she known that one of the consequences of this decision could be the development of secondary complications. (i.e. increased risk of morbidity or mortality).

#### **Case Study #4- Medical Necessity**

*Steve is a physical therapist and owns his own therapy clinic. He recently signed a contract with an HMO to provide physical therapy services. The contract stipulates that Steve will be compensated on a case rate basis. (A fixed amount of money per patient, based on diagnosis) Steve has performed a thorough cost analysis on this contract and has determined that the financial “breakeven” point (revenue equals expenses) on each of these patients is 5 visits. He informs his staff that all patients covered by this insurance must be discharged by their fourth visit.*

*Is limiting care in this manner ethical?*

Therapists are obligated to propose and provide care that is based on sound medical rationale, patient medical necessity, and treatment efficacy and efficiency. It is unethical to either alter or withhold care based on other extraneous factors without the patient’s knowledge and consent.

In this instance, the decision to limit care is not ethical. The quantity of care is not being determined by the medical necessity of the patient. A therapist must be able to justify all of their professional decisions (such as the discharging of a patient from clinical care) based on sound clinical rationale and practices.

#### **Case Study #5 – Conflicts of Interest**

*Debi Jones PT works in an acute care hospital. She is meeting with a vendor whose company is introducing a new brace onto the market. He offers her 3 free braces to “try out” on patients. The vendor states that if Debi continues to order more braces, she will qualify to receive compensation from his company by automatically becoming a member of its National Clinical Assessment Panel.*

*Does this represent a conflict of interest?*

Yes, there exists a conflict of interest in this situation. Debi has two primary obligations to fulfill. The first is to her patient. It is her professional duty to recommend to her patient a brace that, in her judgment, will benefit them the most. The second obligation is to her employer, the hospital. As an employee of the hospital it is her responsibility to manage expenses by thoroughly and objectively seeking effective products that also demonstrate economic efficiency. The conflict of interest occurs when she begins to accept compensation from the vendor in direct or indirect response for her brace orders. Even if she truly believes it is the best brace for her patient, and it is the most cost-effective brace the hospital could purchase, by accepting the money she has established at least

an apparent conflict of interest. Under this situation she is obligated to disclose to all parties her financial interest in ordering the braces. This disclosure is necessitated because the potential for personal gain would make others rightfully question whether her objectivity was being influenced.

A conflict of interest is a situation in which a person has a private or personal interest that influences the objective exercise of his or her professional duties. As a professional you take on certain responsibilities and obligations to patients, employers, and others. These obligations must take precedence over a therapist's private or personal interests.

In addition to avoiding all real instances of conflict of interest, therapists must also avoid any apparent or potential conflicts as well.

An apparent conflict of interest is one in which a reasonable person would think that the professional's judgment is likely to be compromised, and a potential conflict of interest involves a situation that may develop into an actual conflict of interest.

How do you determine if you are in a conflict of interest, whether actual, apparent, or potential? The key is to determine whether the situation you are in interferes or is likely to interfere with your independent judgment. A good test is the 'trust test': Would relevant others (my employer, my patients, professional colleagues, or the general public) trust my judgment if they knew I was in this situation. Trust is at the ethical heart or core of this issue. Conflicts of interest involve the abuse, actual or potential, of the trust people have placed in professionals. This is why conflicts of interest not only injure particular patients and employers, but they also damage the whole profession by reducing the trust people generally have in therapists.

### **Case Study #6 – Relationships with Referral Sources**

*Larry Jones PT owns a private practice. Business has been poor. He decides to sublease half of his space to an orthopedic surgeon. Larry's current lease is at \$20/sq ft. The doctor wants to pay \$15/sq ft. They come to a compromise of \$17/sq ft. Larry also agrees that if the doctor is his top referral source after 3 months, he'll make him the Medical Director of the facility and pay him a salary of \$500/month.*

*Is this an ethical arrangement?*

No, this agreement is not ethical. The most notable infraction involves offering to designate the physician as Medical Director contingent upon the number of referrals he sends. It is perfectly acceptable (and required in some instances) to have a physician as a Medical Director; however, compensating the Medical Director based on their referral volume is unethical. The arrangement described

in this case study is undeniably a direct offer of cash for patients. Another area of concern is the rent. At first glance, the rent amount of \$17/sq ft seems fair because it was a compromise between the two parties. However, closer scrutiny reveals this to be unethical. The fair market value for rent has been established as \$20/ft. (Larry's current rental agreement with his landlord) By discounting the doctor \$3/sq ft on his rent, Larry is giving a referral source something of value.

It is unethical for a physical therapist to offer anything of value to physicians or any other referral source in direct response for the referral of patients or services. This includes cash, rebates, gifts, discounts, reduced rent, services, equipment, employees, or marketing. Many mistakenly believe that it is a normal acceptable business practice to offer these things to referral sources. It is not. In most states, the practice is not only unethical, but it is also illegal. Exchanges of valued items or services between therapists and referral sources must never have any relationship to the referral of patients. Goodwill gifts of nominal value are acceptable provided that no correlation can be made between the magnitude or frequency of the gift giving and referral patterns. All business agreements and transactions should always be well documented and most importantly, reflect fair market value.



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**Ethics & Jurisprudence – Indiana Physical Therapy**

**Post-Test**

1. Which ethics theory is defined INCORRECTLY? (p. 4-5)
  - A. Utilitarianism is the theory that right and wrong are determined by consequence.
  - B. Social Contract Theory proposes that moral code is created by the people who form societies.
  - C. Ethical Egoism is based on the theory that each person should do whatever promotes their own best interests.
  - D. Natural Law Theory proposes that ethical behavior is a result of inherent traits.
  
2. Which of the following statements is TRUE? (p. 5-6)
  - A. All actions that are legal are also morally right.
  - B. All actions that are morally right are also legal.
  - C. Physical therapy ethics vary state by state.
  - D. The APTA Code of Ethics establishes ethical behavior for all physical therapists; including therapists who are not members of the APTA.
  
3. Which of the following is NOT one of the stated purposes of the APTA's Code of Ethics? (p. 7)
  - A. Provide standards of behavior and performance that form the basis of professional accountability to the public.
  - B. Establish rules that define lawful physical therapy practice.
  - C. Provide guidance for physical therapists facing ethical challenges.
  - D. Establish standards by which the APTA can determine if a physical therapist has engaged in unethical conduct.
  
4. As per the principles of the APTA's Code of Ethics, it is unethical for a physical therapist to have a sexual relationship with \_\_\_\_\_. (p.7-10)
  - A. their patient
  - B. a PTA working under their supervision
  - C. their physical therapy student intern
  - D. All of the above
  
5. According to the Standards of Ethical Conduct for the Physical Therapist Assistant, PTAs shall provide physical therapy services under the direction and supervision of a \_\_\_\_\_. (p. 13-16)
  - A. physical therapist
  - B. physical therapist or physician
  - C. physical therapist, physician, or other qualified health professional
  - D. None of the above

6. The primary goal of the informed consent process is to \_\_\_\_\_. (p. 17-20)
  - A. Provide protection for health care providers against litigation
  - B. Ensure that patients have an opportunity to be informed participants in decisions about their health.
  - C. Improve efficiency and accuracy throughout the health care system.
  - D. Facilitate the practice of evidence-based medicine.
  
7. PT professionals are expected to make a “fiduciary” commitment to their patients. This means that they will \_\_\_\_\_. (p. 20-22)
  - A. Place the needs and interests of their patients before their own.
  - B. Provide only evidence-based care.
  - C. Charge the patient based only on their ability to pay.
  - D. Provide pro bon services.
  
8. Gifts from companies to physical therapists are acceptable only when \_\_\_\_\_. (p. 22-24)
  - A. the primary purpose is the enhancement of patient care and medical knowledge
  - B. each professional in the field receives the same gift without regard to previous product usage
  - C. the company is introducing a new product or service to the market.
  - D. permission is received from the professional’s employer
  
9. Information relating to \_\_\_\_\_ is considered to be individually identifiable health information that is covered under the Privacy Rule of HIPAA. (p. 24)
  - A. An individual’s past present, or future physical or mental health or condition
  - B. The provision of healthcare to the individual
  - C. The past, present, or future payment for the provision of healthcare to the individual
  - D. All of the above
  
10. Which Indiana licensed profession is NOT a recognized referral source for physical therapy services? (p. 27)
  - A. Psychologist
  - B. Dentist
  - C. Acupuncturist
  - D. Advanced practice registered nurse
  
11. Indiana licensed PTs may evaluate and treat individuals without a provider referral for a maximum of \_\_\_\_\_ calendar days beginning with the date of the initiation of treatment. (p. 28)
  - A. 42
  - B. 30
  - C. 21
  - D. 14

12. An Indiana licensed physical therapist may legally perform spinal manipulation without a referral. (p. 28)
- A. True
  - B. False
13. Emergency first aid may be rendered by any person. (p.28)
- A. True
  - B. False
14. An Indiana licensed physical therapist may legally perform sharp debridement without a referral. (p. 30)
- A. True
  - B. False
15. The Indiana Board of Physical Therapy is comprised of \_\_\_\_\_. (p. 30)
- A. 3 PTs, 1 PTA, and 1 unaffiliated resident of the state
  - B. 4 PTs, 1 physician, 1 attorney
  - C. 5 PTs, 1 PTA, and 1 physician
  - D. 3 PTs, 2 physicians, and 1 attorney
16. What level of supervision is required for a physical therapy aide to perform designated tasks? (p. 30)
- A. General supervision by a PTA
  - B. Direct supervision by a PTA
  - C. Indirect supervision by a PT
  - D. Direct supervision by a PT
17. Patients in a rehabilitation facility receiving care from a PTA must be examined by a supervising PT at least once every \_\_\_\_\_. (p. 34)
- A. 7 days
  - B. 14 days
  - C. 21 days
  - D. 30 days
18. Every Indiana licensed PT and PTA must renew their license biennially on or before \_\_\_\_\_. (p. 35)
- A. January 1 of each even-numbered year.
  - B. July 1 of each even-numbered year.
  - C. December 31 of each odd-numbered year
  - D. July of each odd-numbered year

19. Each biennial renewal period, Indiana PTs & PTAs must complete \_\_\_\_\_ (p. 40)
- A. At least 22 hours of continuing competency activities
  - B. At least 10 hours of Category I activities
  - C. 2 hours of ethics and Indiana jurisprudence
  - D. All of the above
20. It is unethical for a physical therapist to \_\_\_\_\_. (p. 47-48)
- A. Have a referring physician as a medical director
  - B. Sublease office space to a potential referral source
  - C. Waive a treatment co-pay for the spouse of a referring physician
  - D. Meet with a physician to educate them about new physical therapy techniques and interventions.

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