

Ethics & Jurisprudence – Mississippi Physical Therapy

Ethics & Jurisprudence - Mississippi Physical Therapy

Goals & Objectives

Course Description

“Ethics & Jurisprudence – Mississippi Physical Therapy” is an online continuing education course for Mississippi 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 and Guide for Professional Conduct for Physical Therapists and assistants, model for ethical decision making, Mississippi Title 30, Part 3103, and hypothetical case analysis.

Course Rationale

This course is designed to educate, promote and facilitate ethical and legal behavior by Mississippi licensed physical therapists and physical therapist assistants. It is intended to fulfill the 3 hours of Ethics & Jurisprudence continuing education required by Title 30, Part 3103, Rule 5.2(3) of the Mississippi Regulations Governing Licensure of Physical Therapists & Physical Therapist Assistants.

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. define the ethical decision making model
3. identify and apply the APTA’s standards of professional ethical conduct
4. define the parameters of informed consent
5. identify components of effective provider-patient communication
6. differentiate between appropriate and inappropriate relationships
7. define conflict of interest and identify situations that demonstrate it
8. identify the principles of confidentiality as defined under HIPAA guidelines
9. recognize all of the rights and responsibilities of physical therapy licensure as defined by Title 30, Part 3103 of the Mississippi Administrative Code.
10. apply the ethical decision making model to clinical situations to determine appropriate professional behavior

Course Provider – Innovative Educational Services

Course Instructor - Michael Niss, DPT

Target Audience - Mississippi licensed physical therapists and physical therapist assistants

Course Educational Level - This course is applicable for introductory 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 – Three (3) hours of continuing education credit

Fees - \$14.95

Conflict of Interest - No conflict of interest exists for the presenter or provider of this course.

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.

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Ethics Overview

The word “ethics” is derived from the Greek word *ethos* (character). 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 Stewart 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

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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?

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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.

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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.

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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.

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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.

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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 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

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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

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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

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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.

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.

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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 discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.

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

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

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

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.

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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.

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

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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

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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

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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

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- 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.

Mississippi Regulations Governing Licensure of Physical Therapists & Physical Therapist Assistants (Title 30, Part 3103)

(The following is an abridged version of the Mississippi physical therapy regulations. To read Title 30, Part 3103 in its entirety, please go to: <https://www.msbt.ms.gov/secure/pdf/FinalAdoptionCurrentRegs.pdf>)

Chapter 2: Professional Identification

Rule 2.1 Professional Titles and Abbreviations.

The preferred title for use by the licensed physical therapist is the initials PT. The licensed physical therapist assistant may use the title PTA. A person issued a license to practice pursuant to the Act by the Mississippi State Board of Physical Therapy may use the titles physiotherapist, licensed or registered physical therapist, licensed or registered physical therapist assistant, and the abbreviations PT, DPT, LPT, RPT and PTA or LPTA, depending upon the license issued by the Board. It shall be unlawful for any person, or business entity, its employees, agents or representatives to in any manner, represent himself/herself or itself as a physical therapist, a physical therapist assistant or someone who provides physical therapy services, or use in connection with his or its name the words or letters physiotherapist, registered or licensed physical therapist, PT, RPT, licensed physical therapist assistant, LPTA, PTA, or any other letters, words, abbreviations or insignia, indicating or implying that he or it is a physical therapist, a physical therapist assistant, or provides physical therapy services, without a valid existing license as a physical therapist or as a physical therapist assistant, as the case may be, issued to that person. It shall be unlawful to employ an unlicensed physical therapist or physical therapist assistant to provide physical therapy services.

Rule 2.2 Production and Display of License.

A person licensed to practice physical therapy in Mississippi shall be issued a "Certificate of Licensure" and "License Identification Card." The licensee shall prominently display the "Certificate of Licensure" or copy thereof at their place(s) of employment. The licensee shall carry the "License Identification Card" with them at all times and show said ID card when requested.

Rule 2.3 Consumer Information Sign.

There should at all times be prominently displayed in the place of business each licensee a sign containing the name, mailing address, and telephone number of the Board and a statement informing consumers that complaints against licensees can be directed to the Board. The consumer information sign shall read: Complaints regarding non-compliance with the Mississippi Physical Therapy Practice Act can be directed to the Mississippi State Board of Physical Therapy, P.O. Box 55707, Phone: (601) 939-5124, Fax: (601) 939-5246, Email: info@msbpt.state.ms.us. The minimum size of the sign shall be 6 inches by 8 inches.

Chapter 3: Practice

Rule 3.1 Referrals.

1. Physical Therapist may evaluate or provide wellness fitness without a referral.
2. A physical therapist licensed under the physical therapy law shall not perform physical therapy services without a prescription or referral from a person licensed as a physician, dentist, osteopath, podiatrist, chiropractor, physician assistant or nurse practitioner. However, a physical therapist may perform physical therapy services without a prescription or referral under the following circumstances:
 - a. To children with a diagnosed developmental disability pursuant to the patient's plan of care.
 - b. As part of a home health care agency pursuant to the patient's plan of care.
 - c. To a patient in a nursing home pursuant to the patient's plan of care.
 - d. Related to conditioning or to providing education or activities in a wellness setting for the purpose of injury prevention, reduction of stress or promotion of fitness.
 - e. To an individual for a previously diagnosed condition or conditions for which physical therapy services are appropriate after informing the health care provider rendering the diagnosis. The diagnosis must have been made within the previous one hundred eighty (180) days. The physical therapist shall provide the health care provider who rendered the diagnosis with a plan of care for physical therapy services within the first fifteen (15) days of physical therapy intervention.

Rule 3.2 Telehealth.

1. Patient Identity and Communication. The physical therapist/physical therapist assistant using telehealth to deliver physical therapy services or who practices tele-physical therapy, upon an initial contact with the patient shall:

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- a. Verify the identity of the patient prior to each session;
- b. Obtain alternative means of contacting the patient;
- c. Arrange for the patient to have alternative means of contacting the physical therapist or physical therapy assistant;
- d. Provide contact methods of alternative communication the physical therapist or physical therapy assistant shall use for emergency purposes;
- e. Use personal identifying information only in secure communications; and
- f. Obtain written, informed consent from the patient or other appropriate person with authority to make health care treatment decisions for the patient before services are provided through telehealth.

2. Informed Consent. The informed consent shall, minimally, inform the patient and document acknowledgement of the risk and limitations and potential benefits associated with:

- a. The use of electronic communications in the provision of physical therapy;
- b. The potential breach of confidentiality, or inadvertent access, of protected health information using electronic communication in the provision of physical therapy; and
- c. The potential disruption of electronic communication in the use of telehealth;
- d. Video-taping and recording of treatment session.

3. Confidentiality. The licensee shall ensure that the electronic communication is secure to maintain confidentiality of the patient's medical information as required by the Health Insurance Portability and Accountability Act (HIPAA) and other applicable Federal and State laws. Confidentiality shall be maintained through appropriate processes, practices and technology, including disposal of electronic equipment and data

4. Competence and Scope of Practice. A licensee using electronic communication to deliver physical therapy services or who practices tele-physical therapy shall:

- a. Be responsible for determining and documenting that telehealth is appropriate for provision of physical therapy;
- b. Limit the practice of tele-physical therapy to the area of competence in which proficiency has been gained through education and training;
- c. Ensure that confidential communications obtained and stored electronically shall not be recovered and accessed by unauthorized persons when the physical therapist or physical therapy assistant disposes of electronic equipment and data by use of a secure telecommunication mechanism;
- d. Make every attempt to ensure that an on-site physical therapist or physical therapist assistant shall provide the appropriate interventions. If it is determined in-person interventions are necessary;
- e. Perform all evaluations, including initial evaluations, re-evaluations and scheduled discharges with use of a secure electronic mode of communication using video/voice or in person;
- f. Assure the technology proficiency of those involved in patient care.

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5. Maintenance and Retention of Records. The licensee shall document in the file or record which services were provided by tele-health and adhere to the record-keeping requirements of Part 3103, Rule 8.2.

6. Compliance with Laws and Regulations. A licensing practicing tele-physical therapy practitioner must: a. Have an active Mississippi license in good standing to practice telehealth in the state of Mississippi. b. Otherwise be authorized by law to practice in another jurisdiction where the patient is physically present or domiciled. c. Abide by the Board's law and rules and regulations and all current standards of care requirements applicable to onsite physical therapy services. d. Comply with all other applicable State and Federal Laws, rules and regulations.

Rule 3.3 Intramuscular Dry Needling Manual Therapy.

A. Intramuscular dry needling manual therapy is a physical intervention that uses a filiform needle no larger than 25-gauge needle to stimulate trigger points, diagnose and treat neuromuscular pain and functional movement deficits; is based upon Western medical concepts; requires an examination and diagnosis, and treats specific anatomic entities selected according to physical signs. Intramuscular dry needling manual therapy does not include the stimulation of auricular or distal points or any points based upon areas of Eastern (Oriental) medicine and acupuncture.

B. Intramuscular dry needling manual therapy as defined pursuant to this rule is within the scope of practice of physical therapy.

C. A physical therapist must have the knowledge, skill, ability, and documented competency to perform an act that is within the physical therapist's scope of practice.

D. To be deemed competent to perform intramuscular dry needling manual therapy a physical therapist must meet the following requirements:

1. Documented successful completion of a intramuscular dry needling manual therapy course of study; online study is not considered appropriate training to attain the necessary skills to perform intramuscular dry needling manual therapy.

a. A minimum of 50 hours of face-to-face intramuscular dry needling manual therapy course study must be successfully completed within twelve (12) months. A physical therapist who does not complete the course of study within twelve (12) months after beginning the course of study must begin anew. The Board may grant a one-time extension for the completion of the course of study required by this Rule upon presentation of satisfactory evidence that the physical therapist is unable to complete the required course of study within the time prescribed because of illness, injury, disability, military service, or other documented good cause. A request for an extension of time must be made in writing and filed with the Board no later than thirty (30) calendar days before the expiration of the Board approved twelve (12) month course of study. The extension shall be for no more than six (6) months from the date the Board approves the extension.

b. During the 12-month certification process of intramuscular dry needling manual therapy practice of the dry needling skills learned as part of the course

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curriculum will be permitted to the specific areas and musculature prior to the completion of the 50 hours of required training provided that compensation will not be sought and the physical therapists will not bill for dry needling services until the completion of the 50 hours of training has been fulfilled.

c. The Mississippi State Board of Physical Therapy's website will reflect the names of the therapists that are Board approved to provide intramuscular dry needling manual therapy.

2. The physical therapist must have Board approved credentials for providing intramuscular dry needling manual therapy which are on file with the Board office prior to using the treatment technique.

E. The provider/educator/instructor of the required intramuscular dry needling manual therapy educational course does not need to be a physical therapist. The instructor of the intramuscular dry needling manual therapy course of study must meet the educational and clinical prerequisites as defined in this rule, D(1)(a)&(b) and demonstrate a minimum of two years of intramuscular dry needling manual therapy practice techniques.

F. A physical therapist performing intramuscular dry needling manual therapy in his/her practice must have written informed consent for each patient where this technique is used. The patient must sign and receive a copy of the informed consent form. The consent form must, at a minimum, clearly state the following information:

1. Risks and benefits of intramuscular dry needling manual therapy.

2. Physical therapist's level of education and training in intramuscular dry needling manual therapy.

3. The physical therapist will not stimulate any distal or auricular points during intramuscular dry needling manual therapy.

G. When intramuscular dry needling manual therapy is performed, this must be clearly documented in the procedure notes and must indicate how the patient tolerated the technique as well as the outcome after the procedure.

H. Intramuscular dry needling manual therapy shall not be delegated and must be directly performed by a qualified, licensed physical therapist.

I. Intramuscular dry needling manual therapy must be performed in a manner consistent with generally accepted standards of practice, including but not limited to, aseptic techniques and standards of the center for communicable diseases.

J. Failure to provide written documentation of appropriate educational credentials is a violation of this rule, and is prima facie evidence that the physical therapist is not competent and not permitted to perform intramuscular dry needling manual therapy.

K. This rule is intended to regulate and clarify the scope of practice for the physical therapist.

Rule 3.4 Code of Ethics.

1. All licensees shall comply with the current American Physical Therapy Association Code of Ethics: Standards of Ethical Conduct and the accompanying Guide for Professional Conduct for physical therapists and physical therapist assistants.

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2. All licensees shall comply with the current American Physical Therapy Association Standards of Practice for Physical Therapy and the accompanying Criteria.

Chapter 4: Renewal of License

Rule 4.1 General Provisions.

The Board shall issue licenses which shall be subject to biennial renewal.

1. The licensure period shall be construed as July 1 through June 30 of odd-numbered years for persons whose surnames begin with A through L and the licensure period shall be construed as July 1 through June 30 of even-numbered years for persons whose surnames begin with M through Z. For one time only during 2005, those persons whose surnames begin with M through Z would renew for only one year, and thereafter every two years on even-numbered years.

2. Each individual's licensure renewal group is based on the first letter of his or her last name at the time of the implementation of this rule or at the time of initial licensure, whichever occurred later. Each licensee shall remain in his or her originally assigned licensure renewal group for all subsequent license renewals. Thus, even if a licensee's name is changed, he or she shall remain in the same licensure renewal group as originally assigned.

3. Commencing with the licensure renewal period ending June 30, 2014 a licensee shall be required to provide the Board with a current photo identification every four (4) years from the date of the Board's receipt of the licensee's previous photo identification. The photo must be an approximate size of 2x2 inches, head and shoulder only, full face, front view, plain white background, standard photo stock paper. Scanned or computer-generated photographs must be printed on photo quality paper and must have no visible pixels or dots. Photos can be uploaded to the licensee's profile or the photo can be mailed into the Board office.

Rule 4.2 Procedure for Renewal of License.

The Board will notify licensees approximately sixty (60) days prior to the end of the licensure period. Failure to receive such notification does not relieve the licensee from the responsibility of meeting all requirements for renewal. The method of renewal is as follows:

1. Online Renewals – Licensees may apply for renewal and pay the necessary fees via the Internet. In order to renew a license online, licensees will need to access the Board's website at www.msbpt.ms.gov and choose the login button on the bottom left-hand side of the screen;
2. Continuing education is reported online and licensees are subject to CEU random audits;
3. Submit the renewal fee;
4. Renewals should be completed by the end of the licensure period as indicated on the licensee's certificate and identification card;
5. Renewal applications filed after June 30 are subject to a late fee.

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Rule 4.3 Failure to Renew.

A licensee who does not file, with the Board, all requirements for renewal before the end of the licensure period will be deemed to have allowed his license to lapse. Failure to submit all renewal requirements on or before September 30 shall result in the necessity of the payment of a reinstatement fee in addition to the late fee and renewal fee. Said licensee may be reinstated by the Board, at its discretion, by the licensee's payment of the renewal fee, the late fee, a reinstatement fee and the submission of required continuing education hours provided said application for reinstatement is made within two (2) years after its last expiration date. A license may not be reinstated after having lapsed for two (2) consecutive years. A new application must be made and the licensure regulations in effect at that time must be met.

Rule 4.4 Expired License.

Any person whose license has been expired for more than five years may apply for licensure upon the payment of an application & license fee with the following conditions:

1. Licensee will be subjected to a three (3) month supervisory period;
2. Licensee may only practice under the direct on-site supervision of a currently Mississippi licensed physical therapist;
3. Shall restrict his/her practice to the State of Mississippi;
4. Supervision agreement must be on file and satisfactory to this office prior to the license being issued. The supervision agreement shall be in force for the entire three (3) month supervisory period. This licensee may only practice in the facilities and under the supervision of the licensed physical therapist listed on the supervision agreement of file in this office. Any changes in practice sites and /or supervisors must be reported to this office on a supervision agreement prior to the change taking place. At the end of the supervisory period the supervising physical therapist shall report to the Board completion of satisfactory or unsatisfactory supervision period. If an unsatisfactory supervision period is reported by the supervising physical therapist, the Board, in its discretion may require an additional three (3) month supervisory period;
5. During the supervisory period the supervised physical therapist/physical therapist assistant shall not supervise any currently licensed physical therapist or physical therapist assistant;
6. Complete prescribed remedial courses as approved by the Board.

Chapter 5: Continuing Competence

Rule 5.1 Definition and philosophy.

Each individual licensed as a physical therapist or physical therapist assistant is responsible for optimum service to the consumer and is accountable to the consumer, the employer, and the profession for evidence of maintaining high levels of skill and knowledge. Continuing competence is the ongoing ability of a physical therapist or physical therapist assistant to learn, integrate, and apply the

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knowledge, skill, and judgment to practice as a physical therapist and/or physical therapist assistant according to generally accepted standards and professional ethical standards as defined by APTA and FSBPT.

Rule 5.2 Requirements.

1. Regulations set the requirement of 30 continuing competence units (CCU) to be accrued during each 2-year licensing period (July 1-June 30). No carryover of continuing competence units from one licensure period to another shall be allowed.
2. At least 25 percent (7.5 CCU) of the required continuing competence units earned during each licensure period must be directly related to the clinical practice of physical therapy. Continuing Competence (CC) activities claimed as clinical are subject to review if considered questionable.
3. All licensees must take three (3) hours of study in ethics, professionalism, or jurisprudence per licensing period as part of their total CC requirements.
4. At least 15 of the 30 required continuing competence units must be from Certified Activities (outlined in Rule 5.4).
5. Individuals applying for initial licensure within a licensing period must accrue continuing competence hours on a prorated scale. Written notification of required hours will be sent to the applicant at the time of licensure.
6. Persons who fail to accrue the required continuing competence hours shall be issued a probationary license for one licensure period only. No ensuing license may be probationary as a result of not meeting continuing competence requirements. Failure to accrue the required hours during the CC probationary period may result in sanctions up to and including revocation of license. Hours accrued are first credited for the delinquent hours lacking from the previous licensure period and then applied to the current (probationary) licensing term.
7. Licensees who have accrued the required CC hours within the licensure period but who have not received proof of course completion from CC providers shall be granted 30 days from expiration of licensure in which to provide the Board with proof of completion of courses.

Failure to provide proof within 30 days will result in license being placed on CC probationary status for the entire licensure period.

Rule 5.3 Content Criteria.

The content must apply to the field of physical therapy and must be designed to meet one of the following goals:

1. Update knowledge and skills required for competent performance beyond entry level of the physical therapist/physical therapist assistant at the time the individual entered the profession as described in current legislation and regulations.
2. Allow the licensee to enhance his/her knowledge and skills.
3. Provide opportunities for interdisciplinary learning.
4. Extend limits of professional capabilities and opportunities.
5. Facilitate personal contributions to the advancement of the profession.

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Rule 5.4 Sources of Continuing Competence.

Continuing competence hours may be accrued from the following sources when the content of the programs relates to the profession of physical therapy. The Board reserves the right to determine whether the content relates to the profession of physical therapy:

1. Certified activities are activities that go through a certification process to determine if the activity meets a minimal threshold of required criteria and how well that activity meets additional “desirable” criteria. At least fifteen (15) CCUs are required per licensure period in this category.
 - a. Conferences and continuing competence activities that meet the Standards of Continuing Competence (SCC) as set forth by the Federation of State Boards of Physical Therapy (FSBPT). Credit is applied as awarded. Certificate of completion is required as evidence of compliance.
 - b. Conferences and continuing competence activities provided by the American Physical Therapy Association (APTA), Mississippi Physical Therapy Association (MPTA), and other state chapters and sections of APTA. Credit is applied as awarded. Certificate of completion is required as evidence of compliance.
 - c. Educational programs where continuing competence credit is given and approved by accredited universities. Credit is applied as awarded. Certificate of completion is required as evidence of compliance.
 - d. Attendance at educational programs where continuing competence credit is given and approved by the Mississippi State Board of Physical Therapy.
 - e. Academic course work taken for credit from a regionally accredited college or university. Courses must be on the graduate level for physical therapists. Undergraduate courses are acceptable for physical therapist assistants. Credit for 11 CCUs is applied for each semester credit hour passed with a grade of “C” or better. Transcript with grade or completion status required as evidence of compliance.
 - f. APTA credentialed fellowship or residency. Licensees who are enrolled in a residency or fellowship may be exempt from obtaining the mandatory continuing competence hours while completing the program of study. The required documentation is a letter from the director of residency or fellowship program.
 - g. Exams and assessments (includes, but is not limited to, ABPTS certification and recertification, PTA advanced proficiency certification, and FSBPT Practice Review Tool). Credit for CCUs is applied as awarded with a minimum of 15 CCUs applied. Certification of completion required as evidence of compliance.
2. Approved Activities are activities that are approved but do not go through a formal certification process due to the fact that these activities would be difficult to verify. Approved activities are assigned a set CCU value as a group, based on the criteria, versus each individual activity being assigned a value. Limited to 15 CCUs per licensure period.

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- a. Continuing competence courses and conferences not outlined in Rule 5.4.1 (listed above). Credit for 10 CCUs is applied for courses containing > 32 contact hours. Credit for 5 CCUs is applied for courses containing 8-31 contact hours. Credit for 2 CCUs is applied for courses containing 1-7 contact hours. Certificate of completion is required as evidence of compliance.
- b. Residencies and fellowships not outlined in Rule 5.4.1 (listed above). Credit for 15 CCUs is applied. Certificate of successful completion is required as evidence of compliance.
- c. Exams and Assessments not outlined in rule 5.4.1 (listed above). Credit for CCUs is applied as awarded with a maximum of 11 CCUs per exam or assessment.
- d. Self-study, which may include independent study, or studies directed by a correspondence course, video, internet or satellite program by provider not outlined in Rule 5.4.1 (listed above). One (1) CCU per study topic is applied. Record of study objectives, activities, and time spent to meet objectives, as well as reflection on learning achieved are required as evidence of compliance.
- e. Attendance at in-service education programs pertaining to clinical concepts, safety training, or governmental regulatory training. One (1) CCU per in-service is applied. Learning objectives, program schedule, and verification of attendance from employer are required as evidence of compliance.
- f. Presentations made before physical therapists or other health care professionals and directly related to the profession of physical therapy. Credit for 3 CCUs per presentation/topic is applied. Learning objectives and presentation brochure or flyer are required as evidence of compliance.
- g. Research. Credit for 10 CCUs are applied for Principal and Co-Principal Investigators in internally or externally funded research projects. Title, abstract, funding agency, and grant period are required as evidence of compliance.
- h. Professional publications. Credit for 8 CCUs is applied for each peer-reviewed publication. Credit for 4 CCUs is applied for each non-peer reviewed publication. Copy of article, book chapter, or other work product is required as evidence of compliance.
- i. Clinical Instructorship. Credit for 1 CCU is applied for each 40 hours of clinical supervision with the same student. A maximum of 3 CCUs per clinical rotation for a total of 6 CCUs per licensure period is allowed. Students must be enrolled in CAPTE accredited or eligible DPT or PTA program. Verification of the clinical supervision agreement with the student's educational program and a log reporting supervision hours is required as evidence of compliance. A certificate of completion from the educational program may also be used as evidence of compliance.
- j. Board and Committee Work. Credit for 5 CCUs is applied for assignments requiring time commitment of > 33 hours/year. Credit for 3 CCUs is applied for assignments requiring time commitment of 16-33 hours/year. Organizational materials listing participation, responsibilities, and activities as well as written verification of time spent in activity is required as evidence of compliance.

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k. Structured Interactive Study (i.e. group study, journal club). Credit for 3 CCUs per study group is applied per licensure period. Group attendance records reporting time spent, study group goals, and reflection on goal attainment and learning are required as evidence of compliance.

l. Formal Mentorship (as mentor or as protégé). Credit for 5 CCUs is applied per licensure period. Objectives and action plans, as well as documentation of activities and contact hours are required as evidence of compliance.

3. Unacceptable activities include:

- a. Staff meetings
- b. Presentations or publications directed at lay groups
- c. Orientation to specific work-site programs dealing with organizational structures, processes, or procedures.
- d. Entertainment or recreational meetings or activities.
- e. Self-directed studies other than those previously outlined.
- f. Credit for repetitions of an activity more than once in a licensure period
- g. Routine teaching or research duties as part of a job requirement.
- h. CCUs carried over from one licensure period to another.

Rule 5.5 Reporting Procedures for Continuing Competence.

1. In each licensure period the Board shall randomly select licensees for audit of evidence of compliance with continuing competence activities.
2. Licensees renewing from and after July 1, 2016 must record and report compliance with continuing competence activities through the free online aPTitude program of the FSBPT. <https://pt.fsbpt.net/aPTitude>
3. The online renewal screen will notify the licensee who is subject to audit. It is the licensee's responsibility to comply with the audit requirements.
4. Licensees shall retain evidence of compliance with continuing competence requirements for the preceding licensure period.

Chapter 6: Revocation, Suspension, and Denial of License

Rule 6.1 Standards of Conduct.

Licensees subject to these regulations shall conduct their activities, services, and practice in accordance with this section. The Board, upon satisfactory proof and in accordance with the provision of this chapter and the regulations of the Board, may suspend, revoke, or refuse to issue or renew any license hereunder, censure or reprimand any license, restrict or limit a license, and/or take any other action in relation to a license as the Board may deem proper under the circumstances upon any of the following grounds:

1. Negligence in the practice or performance of professional services or activities.
2. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public in the course of professional services or activities.
3. Perpetrating or cooperating in fraud or material deception in obtaining or renewing a license or attempting the same.

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4. Being convicted of any crime, which has a substantial relationship to the licensee's activities and services or an essential element of which is misstatement, fraud, or dishonesty.
5. Having been convicted of or pled guilty to a felony in the courts of this state or any other state, territory or country. Conviction, as used in this paragraph, shall include a deferred conviction, deferred prosecution, deferred sentence, finding or verdict of guilt, an admission of guilty, or a plea of nolo contendere;
6. Engaging in or permitting the performance of unacceptable services personally or by others working under the licensee's supervision due to the licensee's deliberate or negligent act or acts or failure to act, regardless of whether actual damage or damages to the public are established.
7. Continued practice although the licensee has become unfit to practice as a physical therapist or physical therapist assistant due to:
 - a. Failure to keep abreast of current professional theory or practice; or
 - b. Physical or mental disability; the entry of an order or judgment by a court of competent jurisdiction that a licensee is in need of mental treatment or is incompetent shall constitute mental disability; or
 - c. Addiction or severe dependency upon alcohol or other drugs which may endanger the public by impairing the licensee's ability to practice.
8. Having disciplinary action taken against the licensee's license in another state.
9. Making differential, detrimental treatment against any person because of race, color, creed, sex, religion or national origin.
10. Engaging in lewd conduct in connection with professional services or activities.
11. Engaging in false or misleading advertising.
12. Contracting, assisting, or permitting unlicensed persons to perform services for which a license is required under these regulations.
13. Violation of any probation requirements placed on a license by the Board.
14. Revealing confidential information except as may be required by law.
15. Failing to inform clients of the fact that the client no longer needs the services or professional assistance of the licensee.
16. Charging excessive or unreasonable fees or engaging in unreasonable collection practices.
17. For treating or attempting to treat ailments or other health conditions of human beings other than by physical therapy as authorized by these regulations.
18. Except as authorized in Part 3103 Rule 3.1, for applying or offering to apply physical therapy, exclusive of initial evaluation or screening and exclusive of education or consultation for the prevention of physical and mental disability within the scope of physical therapy, other than upon the referral of a licensed physician, dentist, osteopath, podiatrist, chiropractor, physician assistant or nurse practitioner, or for acting as a physical therapist assistant other than under the direct, on-site supervision of a licensed physical therapist.
19. Failing to adhere to the recognized standards of ethics of the physical therapy profession as established by Board rule.
20. Violations of any provisions of this chapter, Board rules or regulations or a written order or directive of the Board.

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21. Has engaged in any conduct considered by the Board to be detrimental to the profession of physical therapy.

22. The Board may order a licensee to submit to a reasonable physical or mental examination if the licensee's physical or mental capacity to practice safely is at issue in a disciplinary proceeding. Failure to comply with a Board order to submit to a physical or mental examination shall render a licensee subject to the summary suspension procedures described in Part 3103 Rule 6.2 of these regulations.

23. The Board is authorized by section 93-11-153 of the Mississippi Code to suspend the license of any licensee being out of compliance with an order for support. The procedure for the suspension of a license for being out of compliance with an order for support, and the procedure for the re-issuance or reinstatement of a license suspended for that purpose, and the payment of any fees for the re-issuance or reinstatement of a license suspended by that purpose, shall be governed by section 93-11-157 or 93-11-163, as the case may be.

24. Failing to complete continuing competence requirements as established by Board rule.

25. Failing to supervise physical therapist assistants in accordance with this chapter and/or Board rule.

26. Engaging in sexual misconduct. For the purpose of this paragraph, sexual misconduct includes, but is not necessarily limited to: a. Engaging in or soliciting sexual relationships, whether consensual or nonconsensual, while a physical therapist or physical therapist assistant/patient relationship exists. b. Making sexual advances, requesting sexual favors or engaging in other verbal conduct or physical conduct of a sexual nature with patients or clients. c. Intentionally viewing a completely or partially disrobed patient in the course of treatment if the viewing is not related to patient diagnosis or treatment under current practice standards.

27. The erroneous issuance of a license to any person.

28. Failing to maintain adequate patient records. For the purposes of this paragraph, "adequate patient records" means legible records that contain at minimum sufficient information to identify the patient, an evaluation of objective findings, a diagnosis, a plan of care, a treatment record and a discharge plan.

29. Failing to report to the Board any unprofessional, incompetent or illegal acts that appear to be in violation of this law or any rules established by the Board.

Rule 6.6 Sanctions.

The Board may impose any of the following sanctions, singly or in combination, when it finds that an applicant or a licensee has committed any violation listed in section 73-23-59 or Part 3103 Rule 6.1:

1. Revoke the license.
2. Suspend the license, for any period of time.
3. Censure the licensee.
4. Impose a monetary penalty in an amount not to exceed \$500.00 for the first violation, \$1,000.00 for the second violation, and \$5,000.00 for the third violation and for each subsequent violation.

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5. Place a licensee on probationary status and require the licensee to submit to any of the following:
 - a. Report regularly to the Board, or its designee, upon matters which are the basis of probation;
 - b. Continue to renew professional education until a satisfactory degree of skill has been attained in those areas which are the basis of probation; or
 - c. Such other reasonable requirements or restrictions as are proper.
6. Refuse to issue or renew a license.
7. Revoke probation which has been granted and impose any other disciplinary action in this subsection when the requirements of probation have not been fulfilled or have been violated.
8. The Board may reinstate any licensee to good standing under this chapter if, the Board is satisfied that the applicant's renewed practice is in the public interest.
9. Restrict a license; or
10. Accept a voluntary surrendering of a license based on an order of consent from the Board.
11. In addition to any other power that it has, the Board may issue an advisory letter to a licensee if it finds that the information received in a complaint or an investigation does not merit disciplinary action against the licensee.
12. The Board may also assess and levy upon any licensee or applicant for licensure the costs incurred or expended by the Board in the investigation and prosecution of any licensure or disciplinary action, including, but not limited to, the cost of process service, court reports, expert witness, investigators, and attorney fees.

Chapter 8: Physical Therapist Assistant

Rule 8.1 Definition.

A physical therapist assistant (PTA), as defined in Part 3101 Rule 1.3 hereinabove, shall be an individual who meets the qualifications and requirements as set forth in Part 3103 Chapter 1 of these regulations, and has been issued a license by the Board. The roles and responsibilities of a PTA are:

1. To practice only under the direct supervision of a physical therapist licensed to practice in Mississippi.
2. To assist with but not perform patient evaluations.
3. To perform treatment procedures as delegated by the physical therapist but not to initiate or alter a treatment plan.
4. To supervise other supportive personnel as charged by the physical therapist.
5. To notify the physical therapist of changes in the patient's status, including all untoward patient responses.
6. To discontinue immediately any treatment procedures which in their judgment appear to be harmful to the patient.
7. To refuse to carry out treatment procedures that they believe to be not in the best interest of the patient.

Rule 8.2 Direction and Supervision of the physical therapist assistant

1. Supervision Standards. A Mississippi-licensed physical therapist may delegate the performance of selected acts, tasks, functions, or interventions to a Mississippi licensed physical therapist assistant. The physical therapist shall, however, at all times be responsible for the physical therapy plan of care and instructions provided to the physical therapist assistant; interpretation of referrals; oversight of all documentation for services rendered to each client or patient; providing direct care to the patient; and assuring that the physical therapist assistant does not function autonomously. The supervising physical therapist shall, at a minimum:

- a. Ensure that the assignment of responsibilities to the physical therapist assistant is commensurate with his or her qualifications, including training, education, skill level, and experience. In cases when the supervising physical therapist is the direct employer of the physical therapist assistant, the physical therapist shall ensure that the physical therapist assistant holds a valid and current Mississippi license.
- b. Examine and evaluate the patient or client to establish a physical therapy diagnosis, treatment goals, frequency, duration, and plan of care before delegating tasks or interventions to be performed by a physical therapist assistant -- the initial evaluation.
- c. Before a patient is treated by the physical therapist assistant, evaluate the patient and establish a written plan of care to include the treatment initial and ongoing treatment program goals and plans for the patient or client, the elements of the plan of care to be delegated to the physical therapist assistant and predetermined procedures and protocols for acts, tasks, functions, or interventions delegated to the physical therapist assistant.
- d. Review the patient plan of care, treatment goals and delegated tasks with the physical therapist assistant before the physical therapist assistant provides care to a patient for the first time.
- e. The supervising physical therapist shall be readily available in person or by telecommunication to the physical therapist assistant at all times for advice, assistance and instruction while the physical therapist assistant is treating patients or clients or providing physical therapy services.
- f. Hold regularly scheduled and documented in meetings and case conferences with the physical therapist assistant to evaluate the assistant's performance, review records and changes in plan of care, and assess the plan of care. The frequency of the meetings and case conferences is to be determined by the supervising physical therapist based upon the needs of the patient; the supervisory needs of the physical therapist assistant; and prior to any planned discharge. Notwithstanding the aforesaid, meetings and case conferences must take place at least once every sixth physical therapist assistant visit or at least once every thirtieth (30th) calendar day, whichever occurs first and be documented in the patient or client record.
- g. Reevaluate the patient as previously determined during the initial evaluation, or more often if necessary, and modify the treatment, goals and plan as needed. The physical therapist assistant shall not alter a treatment

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plan or program without the prior evaluation by, and approval of, the supervising physical therapist. A supervising physical therapist must, however, re-evaluate and render personal treatment to a patient receiving physical therapy services from a physical therapist assistant a minimum of at least once every sixth (6th) physical therapist assistant visit or at least once every thirtieth (30th) calendar day, whichever occurs first.

h. Treat and assess the patient or client for his or her final treatment session, establish a discharge plan and write a discharge summary/status. If the supervising physical therapist is unable to carry out the provisions of this paragraph due to an emergency or unforeseen situation, an explanation of the circumstances constituting the emergency or unforeseen event must be documented in the treatment record of such patient.

2. Physical Therapist Assistants under Supervision. It is the responsibility of the physical therapist to determine the number of physical therapist assistants he or she can supervise safely and competently. However, in no case shall the physical therapist supervise more than a total of four (4) physical therapist assistants and/or physical therapy students at any point in time during the physical therapist's work day. The number of supervisees is inclusive of all geographic locations or employing agencies.

3. Documentation Requirements.

a. A written record of physical therapy treatment shall be maintained for each patient. The written record shall include:

i. A prescription or referral when required showing the written request for physical therapy evaluation or treatment signed by a healthcare provider lawfully authorized to make such request.

ii. Written documentation in each patient's record, along with the physical therapist's signature, of the treatment program goals and plan of care. An initial physical therapy evaluation shall not be documented or signed by a physical therapist assistant or any other personnel.

iii. Progress notes regarding the client's or patient's subjective status, changes in objective findings, and progression or regression toward established goals.

iv. A record of the reassessment or re-evaluation of the patient or client, written and signed by the supervising physical therapist.

v. Written documentation of each patient or client visit which includes specific treatment and services provided.

vi. Written documentation of supervisory visits and/or conferences -- including the date of visit, treatment plans and changes in the treatment plan; other communications between the supervising physical therapist and the physical therapist assistant; and findings and subsequent decisions made. The written documentation must be signed and dated by the supervising physical therapist or the physical therapist assistant.

vii. Documentation of a discharge evaluation by the supervising physical therapist and a discharge summary which must be written and signed by

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the supervising physical therapist. If the supervising physical therapist is unable to provide a patient discharge evaluation and plan, the reason for or circumstances of such inability must be documented in the physical therapy treatment record of such patient.

viii. Accurate patient or client treatment and billing records.

b. A signature stamp shall not be used in lieu of a written signature on physical therapy patient or client records. Forms of electronic signatures, established pursuant to written policies and procedures to assure that only the author can authenticate his or her own entry, may be acceptable.

4. The supervision requirements stated in these regulations are minimal. It is the professional responsibility and duty of the licensed physical therapist to provide the physical therapist assistant with more supervision if deemed necessary in the physical therapist's professional judgment.

Ethics Case Studies

Case Study #1 – Confidentiality

John Jones PT, Sue Brown (therapy receptionist), and Mary Smith (Marketing Director), 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, the facility's Marketing Director, most likely has no compelling

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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 – 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 leaves.

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

Informed consent is the process by which a fully informed patient can participate in choices about their health care. It originates from the legal and ethical right the patient has to direct what happens to their body and from the ethical duty of the therapist to involve the patient in her health care.

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 complete informed consent includes a discussion of the following elements:

- the nature of the decision/procedure
- reasonable alternatives to the proposed intervention
- the relevant risks, benefits, and uncertainties of each alternative
- the consequences on non-treatment
- the goals of treatment
- the prognosis for achieving the goals
- assessment of patient understanding
- the acceptance of the intervention by the patient

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.

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The therapist's actions in this case 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 #3- 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 #4 – 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.

Case Study #5 – 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 and compensate the physician as the 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. 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/sqft. (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 - Mississippi Physical Therapy
Post-Test

1. _____ is the theory that proposes ethical behavior is a result of developed or inherent character traits.
 - A. Virtue Ethics
 - B. Utilitarianism
 - C. Social Contract Theory
 - D. Ethical Intuitionism

2. Which of the following statements is TRUE?
 - 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?
 - 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 _____.
 - 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, physical therapist assistants shall provide physical therapy services under the direction and supervision of a _____.
 - A. Physical therapist
 - B. physical therapist or physician
 - C. physical therapist, physician, or other qualified health care professional
 - D. None of the above

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6. Gifts from companies to PTs are acceptable only when _____.
 - A. each professional in the field receives the same gift without regard to previous product usage
 - B. the primary purpose is the enhancement of patient care and medical knowledge.
 - C. the company is introducing a new product or service to the market.
 - D. permission is received from the professional's employer

7. Which of the following is NOT one of the specific circumstances that Mississippi licensed PTs may provide physical therapy treatment without a referral?
 - A. A child with a diagnosed developmental disability.
 - B. A patient in a nursing home.
 - C. An athlete with an acute musculoskeletal injury
 - D. A patient receiving PT care as part of a home health agency

8. Which of the following is a Mississippi physical therapy biennial continuing education requirement?
 - A. At least 25% of CCUs must be directly related to the clinical practice of physical therapy
 - B. 3 hours of ethics, professionalism, or jurisprudence
 - C. At least 15 of the 30 required CCUs must be from certified activities.
 - D. All of the above

9. How frequently must a supervising PT re-evaluate and render personal treatment to a patient receiving physical therapy from a PTA?
 - A. Monthly
 - B. Bimonthly
 - C. Every fifth visit
 - D. Once every 6th PTA visit or once every 30th calendar day, whichever occurs first.

10. It is unethical for a physical therapist to _____.
 - A. have a physician as a medical director
 - B. sublease office space to a potential referral source
 - C. waive the insurance 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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