

Ethics - Oklahoma Physical Therapy

Ethics – Oklahoma Physical Therapy

Goals & Objectives

Course Description

“Ethics – Oklahoma Physical Therapy” is an online continuing education course for Oklahoma 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 discussions on the theoretical basis for ethical decision-making, informed consent, confidentiality, conflicts of interest, selected sections of the Oklahoma Physical Therapy Practice Act and Title 435, Chapter 20 of the Oklahoma Administrative Code, the APTA’s Code of Ethics, and hypothetical ethics case studies.

Course Rationale

This course was developed to educate, promote, and facilitate ethical and legal behavior by Oklahoma licensed physical therapists and physical therapist assistants. It is intended to meet the 3-hour Ethics CE requirement as mandated by 435:20-9-2 (b)(2) of the Oklahoma Administrative Code.

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 Code of Ethics.
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.
9. apply the ethical decision-making model to clinical situations to determine appropriate professional behavior.
10. recognize all of the rights and responsibilities of physical therapy licensure as defined by the Oklahoma Physical Therapy Practice Act and Title 435, Chapter 20 of the Oklahoma Administrative Code.

Course Provider – Innovative Educational Services

Course Instructor - Michael Niss, DPT

Target Audience - Oklahoma 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 asynchronous course available continuously.

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

Continuing Education Credits – Three hours of continuing education credit

Course Fee - \$14.95

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

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

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Course Outline

	Time
Goals and Objectives	0:00
Outline	
Ethics Overview	
Ethics Theories	0:15
Model for Ethical Decision Making	0:30
APTA Code of Ethics	0:45
Informed Consent	1:25
Relationships	1:30
Gifts and Conflicts of Interest	1:35
Confidentiality	1:40
Oklahoma Administrative Code	1:45
General Provisions	
Regulation of Practice	
Supervision of Physical Therapist Assistants	
Professional Development	
Oklahoma Physical Therapy Practice Act	2:15
Refusal, Suspension, or Revocation of License	
Referrals	
Case Studies	2:30
Case Study #1 – Confidentiality	
Case Study #2 – Qualifications of Practice	
Case Study #2 – Informed Consent	
Case Study #3 – Medical Necessity	
Case Study #4 – Conflict of Interest	
Case Study #5 – Relationships with Referral Sources	
References	
Post-Test	3:00

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Ethics Overview

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

Ethics are important on several levels.

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

Ethics vs. Morals

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

Ethical Questions

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

Ethics Theories

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

Utilitarianism

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

Social Contract Theory

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

Deontological or Duty Theory

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

Ethical Intuitionism

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

Ethical Egoism

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

Natural Law Theory

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

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Virtue Ethics

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

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

Beneficence: the duty to do good.

Confidentiality: the duty to respect privacy of information.

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

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

Nonmaleficence: the duty to cause no harm.

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

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

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

Veracity: the duty to tell the truth.

Model for Ethical Decision Making

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

Are my actions legal?

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

It is illegal for a pedestrian to cross a busy street anywhere other than at the designated crosswalk (jaywalking). A man is walking down a street and sees someone fall and injure themselves on the other side of the street. He immediately crosses the street outside of the crosswalk to attend to the injured

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person. Are his actions legal? Are they moral? What if by stepping into the street he causes a car to swerve and to strike another vehicle?

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

Are my actions ethical?

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

Are my actions fair?

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

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

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

APTA Code of Ethics

Preamble

The vision of the American Physical Therapy Association is "transforming society by optimizing movement to improve the human experience." Our profession's charge, as we strive to be an inclusive moral community that is diverse and equitable, is to meet the health needs of all people. APTA is a voluntary professional society that strives both to serve APTA members and to support the

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profession as a whole. Ethical conduct by physical therapists and physical therapist assistants is vital to the standing of the profession.

The Code of Ethics for the Physical Therapy Profession established by APTA is the ethical foundation to which APTA members commit and was developed to provide guidance and define the ethical expectations for the profession. The Code of Ethics establishes the ethical framework guiding the conduct of all members of the physical therapy profession (physical therapists and physical therapist assistants) throughout their careers, in all practice settings, and in all roles relating to patient and client management, consultation, education, research, and administration. The Code of Ethics also provides the public with ethical standards to which we aspire and for which we are accountable.

Fundamental to the Code of Ethics is the obligation of the physical therapy professional to educate, enable, and empower the public to facilitate greater independence, health, wellness, and enhanced quality of life. Physical therapists and physical therapist assistants strive for the highest standards of ethical conduct based on the core values of the profession and the ethical principles (respect for autonomy, beneficence, non-maleficence, justice, veracity, and fidelity) that are part of ethical action at all levels: individual, organizational, and societal. The Ethical Commitments set forth in the Code of Ethics are important to patients, clients, the public, colleagues, and other health care providers. The Ethical Commitments detail the elements of the ethical fiduciary duty of physical therapists and physical therapist assistants to act in the best interests of their patients and clients.

Regulators and others may rely on the Code of Ethics in assessing the conduct of physical therapists and physical therapist assistants. The Standards of Conduct set forth in the Code of Ethics are used by the APTA Ethics and Judicial Committee to assess whether APTA members have engaged in unethical conduct. At all times the physical therapist maintains responsibility for all physical therapist services. The physical therapist assistant shall work in collaboration with and under the supervision of the physical therapist for select interventions when appropriate. Student physical therapists and student physical therapist assistants have the responsibility to adhere to the Code of Ethics during their entire academic program under the guidance of faculty and supervising clinical instructors.

APTA Code of Ethics Overview

The nine Ethical Commitments are: Respect, Integrity, Accountability, Maintaining Professional Relationships, Compassion and Trust, Responsible Business and Organizational Practices, Direction and Supervision, Professional Expertise, and Societal Responsibility.

The Code serves two purposes:

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1. It delineates enforceable Standards of Conduct in accordance with those Ethical Commitments that APTA enforces with regard to APTA members. The Standards of Conduct address the actions of physical therapists and physical therapist assistants in their roles relating to patient and client management, consultation, education, research, and administration.
2. It provides aspirational illustrative examples of Ethical Commitments that guide physical therapists and physical therapist assistants toward ethical courses of action in professional and volunteer roles related to their field.

This Code of Ethics is not exhaustive; that is, the Ethical Commitments and Standards of Conduct cannot address every possible situation. In some circumstances, APTA may set higher expectations than legal requirements applicable to physical therapist and physical therapist assistant members that are enforced by state licensing authorities. In other circumstances, the enforceable Standards of Conduct may not address behavior that, although unethical, does not relate to the core professional roles of physical therapist and physical therapist assistant members. All physical therapist and physical therapist assistant members shall act in an ethically responsible manner, using the Ethical Commitments set forth in the Code of Ethics to guide their decisions and actions.

The Code of Ethics does not instruct the individual professional on what decision to make or how to act; rather, it provides guidance for ethical decision making. Ethical decision-making is a process by which the Ethical Commitments and Standards of Conduct need to be taken into consideration as the professional makes an ethical judgment. In addition to seeking guidance from the Code of Ethics, PTs, PTAs, and students should also seek advice from trusted mentors or colleagues when ethical issues arise, using the Code as a guide for deliberation and action.

Ethical Principles

The nine Ethical Commitments for the physical therapy profession build on the ethical principles of autonomy, beneficence, nonmaleficence, justice, veracity, and fidelity, which are the pillars of ethical decision-making. PTs and PTAs should carefully consider, balance, and weigh these commitments within the context of the situation in making ethical judgments that are in the best interest of the patient or client and society. Members of the physical therapy profession shall abide by the ethical principles of:

Autonomy

Respect the rights of individuals to make decisions and determinations about their life and body to the greatest extent possible. Respecting autonomy includes the imperative to always respect another's privacy, maintain confidentiality, and obtain informed and ongoing consent in every interaction involving physical touching of another individual.

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Beneficence

Take action to ensure the welfare and safety of the individuals with whom they make professional decisions, to advance the good of the individual and society.

Nonmaleficence

Make decisions and take actions with the intention to prevent or minimize injury, harm, or wrongdoing.

Justice

Make objective decisions that result in the most equitable outcome possible, as justice is an expression of the mutual recognition of respect for each other's human dignity and an acknowledgement that we live together in an interdependent community.

Veracity

Be honest and truthful in all professional decisions and actions, with all internal and external parties.

Fidelity

Treat all individuals (people, groups, and populations) with respect, fairness, discretion, and integrity.

Ethical Commitments and Standards of Conduct

As applied to the physical therapy profession, APTA builds on these principles to identify nine Ethical Commitments to which all APTA members should aspire and which serve as a basis for APTA's enforceable Standards of Conduct.

1. Respect

Physical therapists and physical therapist assistants shall respect the inherent dignity and rights of all individuals.

Standards of Conduct:

1.1 Physical therapists and physical therapist assistants shall not discriminate against any person.

1.2 Physical therapists and physical therapist assistants shall protect patients' and clients' confidential information and not disclose that confidential information except as authorized by the patient or client or as permitted or required by law.

Aspirational Illustrative Examples:

1.A Physical therapists and physical therapist assistants shall strive to acknowledge and respect an individual's known identity and culture.

1.B Physical therapists and physical therapist assistants shall strive to recognize their explicit and implicit personal biases.

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2. Integrity

Physical therapists and physical therapist assistants shall act with professional integrity and responsibility, and fulfill their respective legal and ethical obligations.

Standards of Conduct:

2.1 The physical therapist shall retain full responsibility for all physical therapist services provided under the provisions of the physical therapist's license, including all aspects of the evaluation and management of the patient or client.

2.2 Physical therapists and physical therapist assistants shall obtain ongoing informed consent after providing information that is understandable, honest, and necessary to allow the patient or client or their surrogate to make informed decisions about participation in physical therapist services or research.

2.3 Physical therapists and physical therapist assistants having knowledge that, in their reasonable judgment, raises a substantial question as to whether a colleague is unfit to perform their professional responsibilities with competence and safety shall report this information to the appropriate authorities.

2.4 Physical therapists and physical therapist assistants shall address known illegal or unethical acts by physical therapy personnel or that affect physical therapist services.

2.5 Physical therapists and physical therapist assistants shall comply with applicable mandatory reporter laws for suspected cases of abuse, neglect, or exploitation involving children or vulnerable adults.

2.6 Physical therapists and physical therapist assistants involved in research shall comply with accepted standards governing the protection of research participants.

Aspirational Illustrative Examples:

2.A Physical therapists and physical therapist assistants shall strive to discourage misconduct by any physical therapy personnel or other health care professionals and make appropriate reports of known illegal or unethical acts, including verbal, physical, emotional, or sexual harassment.

2.B Physical therapists and physical therapist assistants shall strive to demonstrate integrity in their relationships with patients and clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.

2.C Physical therapists and physical therapist assistants shall strive to ensure that they take appropriate action to address known illegal or unethical acts by physical therapy personnel or that affect physical therapist services, such as by speaking directly to the individual, consulting with mentors, or reporting the misconduct to a supervisor or relevant legal authority.

3. Accountability

Physical therapists and physical therapist assistants shall be accountable for making sound professional judgments and decisions within the scope of practice established by laws and regulations.

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Standards of Conduct:

3.1 Physical therapists and physical therapist assistants shall not exceed their professional, jurisdictional, and personal scopes of practice and shall communicate with, collaborate with, or refer to a peer or other health care professionals when necessary.

3.2 Physical therapists and physical therapist assistants shall practice without impairment from substance misuse and without impairment from cognitive deficiency or mental illness that, even with appropriate reasonable accommodation, adversely affects their practice.

3.3 Physical therapists and physical therapist assistants shall comply with applicable local, state, and federal laws and regulations, including any duty to report when concerned about the safety of other individuals.

Aspirational Illustrative Examples:

3.A Physical therapists shall strive to demonstrate independent and objective professional judgment and make decisions in the patient's or client's best interests in all settings.

3.B Physical therapists shall strive to make professional judgments and decisions that are informed by professional standards, evidence, provider knowledge and experience, and patient and client values.

3.C Physical therapist assistants shall strive to make decisions in the patient's or client's best interests, in consultation with the physical therapist.

3.D Physical therapists and physical therapist assistants shall strive to be accountable for the accuracy and truthfulness of information they disseminate, including in the use of emerging technologies, such as social media and artificial intelligence.

4. Maintaining Professional Relationships

Physical therapists and physical therapist assistants shall respect the boundaries of professional, therapeutic, organizational, and personal relationships to promote a safe environment.

Standards of Conduct:

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

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

4.3 Physical therapists and physical therapist assistants shall not harass anyone verbally, physically, emotionally, or sexually.

4.4 Physical therapists shall provide reasonable notice and information about alternative sources for obtaining care if the physical therapist terminates the provider relationship while the patient or client continues to need physical therapist services.

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Aspirational Illustrative Examples:

4.A Physical therapists and physical therapist assistants shall avoid initiating or entering into sexual relationships with individuals over whom they have significant influence on patients' and clients' care decisions and should refer patients and clients to other providers if an existing close personal or sexual relationship with such a person might influence or impinge on the integrity of the relationship between the provider and patient or client.

4.B Physical therapists and physical therapist assistants shall strive to collaborate with patients and clients to empower them in making decisions about their health care.

4.C Physical therapists and physical therapist assistants shall strive to create an inclusive and civil work environment that strives to promote each colleague's sense of belonging.

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

5. Compassion and Trust

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

Standards of Conduct:

5.1 Physical therapists and physical therapist assistants shall provide the information necessary to allow patients and clients, or their surrogates, to make informed decisions about physical therapist services or participation in clinical research, including ensuring that information regarding the authorship of clinical documentation, patient education materials, publications, and presentations is truthful, accurate, and relevant.

5.2 Physical therapists and physical therapist assistants shall address barriers to communication and comprehension with recipients of services, caregivers, students, and research participants.

Aspirational Illustrative Examples:

5.A Physical therapists and physical therapist assistants shall strive to demonstrate care and compassion in the provision of physical therapist services.

5.B Physical therapists and physical therapist assistants shall strive to be responsible and accountable for the use of respectful, accurate, and truthful written, verbal, and nonverbal communication in all forms, including social media.

5.C Physical therapists and physical therapist assistants shall strive to recognize the public trust placed in them as health care professionals and maintain professional responsibility when information is disseminated using current and emerging technologies, including but not limited to social media and artificial intelligence.

6. Responsible Business and Organizational Practices

Physical therapists and physical therapist assistants shall promote accountable and truthful organizational behaviors and business practices.

Standards of Conduct:

6.1 Physical therapists and physical therapist assistants shall provide information about their services that is truthful and accurate and shall not make misleading representations in any forms of communication, including billing.

6.2 Physical therapists and physical therapist assistants shall ensure that documentation for physical therapist services accurately reflects the provider, nature, and extent of the services provided.

6.3 Physical therapists and physical therapist assistants shall disclose any conflicts of interest and not permit any conflicts of interest to interfere with professional judgments and decisions.

6.4 Physical therapists and physical therapist assistants shall not, at any time, accept gifts or other considerations that influence or give an appearance of influencing their professional judgment and decision-making.

6.5 Physical therapists and physical therapist assistants shall fully disclose any financial interest they have in products or services that they recommend to patients and clients or to the public.

6.6 Physical therapists shall ensure that patients and clients are informed of their financial obligations prior to incurring charges so that shared decision-making can be incorporated into the treatment plan.

6.7 Physical therapists and physical therapist assistants shall not knowingly enter into or continue any employment or other arrangements that prevent them from fulfilling professional and ethical obligations to patients and clients.

Aspirational Illustrative Examples:

6.A Physical therapists and physical therapist assistants shall strive to provide relevant and truthful information to current and prospective patients and clients about the services to be provided.

6.B Physical therapists and physical therapist assistants shall strive to promote environments that support independent and accountable professional judgment as well as ethical and accountable decision-making.

6.C Physical therapists and physical therapist assistants shall strive to seek compensation that supports the provision of legal, safe, and effective physical therapist services.

7. Direction and Supervision

Physical therapists and physical therapist assistants shall provide appropriate and timely direction to and communication with anyone over whom they have legal supervisory responsibility.

Standards of Conduct:

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- 7.1 Physical therapists shall ensure that all duties directed to other physical therapy personnel are congruent with the credentials, qualifications, competencies, and legal scope of practice or scope of work of the individual.
- 7.2 Physical therapist assistants shall provide physical therapist services under the direction and supervision of a physical therapist and shall communicate with the physical therapist when the patient's or client's status requires modification to the established plan of care.
- 7.3 Physical therapists shall exercise primary responsibility for the supervision of physical therapist assistants and support personnel.
- 7.4 Physical therapist assistants shall support and respect the supervisory role of the physical therapist to ensure quality of care and promote patient and client safety.
- 7.5 Physical therapist assistants shall take responsibility to communicate in a timely manner to the supervising physical therapist any areas in which they do not have the necessary level of knowledge and skill to practice safely and effectively.

Aspirational Illustrative Example:

7.A Physical therapists and physical therapist assistants shall strive to take responsibility to mentor learners in order to help the learners develop knowledge, skills, behaviors, and attitudes that will enable them to provide safe and effective care while embodying professionalism.

8. Professional Expertise

Physical therapists and physical therapist assistants shall enhance their expertise and competency through career-long acquisition and refinement of knowledge, skills, abilities, and professional behaviors.

Standards of Conduct:

- 8.1 Physical therapists shall recognize and practice within the limits of their skills and competence and refer a patient or client to another health care professional when it is in the best interests of the patient or client.
- 8.2 Physical therapists and physical therapist assistants shall practice consistent with accepted current standards of care.

Aspirational Illustrative Examples:

- 8.A Physical therapists and physical therapist assistants shall strive to develop and maintain competence and exercise appropriate care in using current and emerging technologies, including but not limited to social media and artificial intelligence.
- 8.B Physical therapists and physical therapist assistants shall strive to engage in professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, health care delivery, and technology.
- 8.C Physical therapists and physical therapist assistants shall strive to evaluate the strength of evidence and applicability of content presented during

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professional development activities before integrating the content or techniques into practice, as appropriate to their professional roles.

8.D Physical therapists and physical therapist assistants shall strive to cultivate and support practice environments that support professional development, career-long learning, and excellence.

8.E Physical therapists and physical therapist assistants shall strive to reflect on and take action needed to maintain their own physical, emotional, and mental health, and seek outside assistance when needed.

9. Societal Responsibility

Physical therapists and physical therapist assistants shall participate in efforts to meet the health needs of people locally, nationally, and globally.

Aspirational Illustrative Examples:

9.A Physical therapists and physical therapist assistants shall strive to provide resources to assist those who they believe are in harm's way.

9.B Physical therapists and physical therapist assistants shall strive to recognize and address the multiple determinants of health that impact an individual's ability to optimize their own health and shall strive to provide appropriate suggestions to patients and clients of available community resources.

9.C Physical therapists and physical therapist assistants shall strive to 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.

9.D Physical therapists and physical therapist assistants shall strive to recognize and respect the unique roles of other health professions and engage in interprofessional collaboration to meet the individual needs of people as well as improve access to appropriate services.

9.E Physical therapists and physical therapist assistants shall strive to provide pro bono physical therapist services or support organizations that meet the needs of people who are economically disadvantaged, uninsured, or underinsured.

9.F Physical therapists and physical therapist assistants shall strive to be responsible stewards of health care services and advocate for just utilization of those services, including taking action to reduce barriers to access.

9.G Physical therapists and physical therapist assistants shall strive to educate the public about the scope of practice and benefits of physical therapy as part of interprofessional collaborative practice to protect and advance the health and well-being of individuals, communities, and populations.

9.H Physical therapists and physical therapist assistants shall strive to be good stewards of limited resources and take action to avoid unnecessary waste of those resources.

Informed Consent

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

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

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

Consent for Multiple Treatments

Although consent is always specific, it is not the same as saying that separate consent is always required for every episode of repeated treatment. When the plan of care for a given diagnosis involves repeated treatments or procedures—for example, a course of diagnostic tests or ongoing therapy—practitioners do not need to obtain consent for each individual episode.

Blanket Consent

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

Moreover, seeking consent "in case" a patient should need some future intervention that is not related to that patient's current clinical status violates the fundamental ethical norm that patients must make decisions about proposed treatments or procedures in the context of their present situation. As a "patient-centered action," informed consent involves the contemporaneous bodily integrity, rights, dignity, intelligence, preferences, interests, goals, and welfare.

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If a patient's condition changes enough to warrant a change in the plan of care, the practitioner must explain to the patient (or authorized surrogate) how the situation has changed, establish goals of care in light of the new situation, recommend a new plan of care, and obtain informed consent for the new plan or for specific treatment(s) or procedure(s) now recommended.

Notification versus Consent

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

Refusing Treatment

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

Practitioners should take care not to assume that a patient who refuses recommended treatment lacks decision-making capacity. A capacity assessment is appropriate if the practitioner has reason to believe the patient might lack one or more of the components of decision-making capacity. When decision-making capacity is not in question, practitioners must respect the patient's decision to decline an intervention, even if they believe the decision is not the best one that could have been made. However, this does not mean that health care professionals should never question the patient's decision, or never try to persuade the patient to accept treatment. For example, by exploring the reasons for refusal with the patient, a practitioner might learn that the patient simply needs more information before deciding to proceed.

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

Asking in a nonjudgmental way, "What leads you to this conclusion?" can then help the practitioner to understand the reasons for the patient's decision to decline recommended treatment. It can also help to identify concerns or fears the

patient may have about the specific treatment that practitioners can address. The aim should be to negotiate a plan of care that promotes agreed on goals of care.

Resisting Treatment

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

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

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

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

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

Relationships

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

Professionalism

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

Patients who come to health care professionals when they are ill and vulnerable bring with them expectations about this interaction and how clinicians should behave toward them as health care professionals, though patients are not always able to articulate those expectations clearly. Patients should be able to trust that their interests and welfare will be placed above those of the health care professional, just as they should be confident, they will be treated with respect, and be informed so that they can make their own health care decisions to the greatest extent possible. Professionals, as such, are held to different standards of conduct from other persons. Relationships and interactions that may be ethically unproblematic among nonprofessionals may be unacceptable when one of the parties is a professional. An individual may have a personal interest that is perfectly acceptable in itself, but conflicts with an obligation the same individual has as a health care professional.

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

Boundaries

Boundaries define the professional relationship as fundamentally respectful and protective of the patient and as dedicated to the patient’s well-being and best interests. A boundary violation occurs when a health care professional’s

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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.

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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

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powerful motivators, ethical standards explicitly require health care professionals to place patient interests above their own.

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

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

The social dynamics of the gift relationship, the potential for gifts subtly to bias health care professionals' prescribing practices and clinical decisions, and the obligation of health care professionals to avoid acting in ways that might undermine public trust all argue for the adoption of clear, robust policies regarding the acceptance of gifts from companies. Creating a workplace in which professionals no longer routinely expect or accept gifts from industry is a challenging task that calls for professional role modeling and sustained, coordinated efforts on the part of clinical and administrative leaders, as well as development and careful implementation of clear, well-considered policy.

Confidentiality

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

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

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

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

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

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

Oklahoma Administrative Code, Title 435, Chapter 20

(To read the O.A.C., Title 435, Chapter 20 in its entirety, go to:
https://www.okmedicalboard.org/physical_therapists/download/456/PTRULES_09.2023.pdf

Subchapter 1. General Provisions

435:20-1-1.1. Definitions

"General supervision" means the responsible supervision and control of the practice of the licensed physical therapist assistant by the supervising physical therapist. The supervising therapist is regularly and routinely on-site, and every three months will provide a minimum of one (1) co-treatment of face to face, real time interaction with each physical therapist assistant providing services with his/her patients. These co-treatments will be documented in the medical record and on a supervision log, which is subject to inspection. When not on-site, the supervising therapist is on call and readily available physically or through direct telecommunication for consultation.

"Immediate Supervision" means the supervising physical therapist or physical therapist assistant is on the premises and in attendance when patient care is being delivered.

"On-site supervision" or "Direct supervision" means the supervising physical therapist is continuously on-site and present in the department or facility where services are provided, is immediately available to the person being supervised

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and maintains continued involvement in appropriate aspects of each treatment session in which assistive personnel are involved in components of care.

"Physical Therapist of Record" means the physical therapist who assumes the responsibility for the provision and /or supervision of physical therapy services for a patient, and is held accountable for the coordination, continuation and progression of the plan of care.

"Physical Therapy Aide" means a person on-the-job trained and working under the immediate supervision of a physical therapist or physical therapist assistant who performs designated and supervised routine tasks as outlined in 435:20-7-1.

"Re-examination/Re-evaluation/Assessment" means visits by the physical therapist, in the presence of the patient, to assess the patient's current status, gather additional data, and update the plan of care.

"Supervising Physical Therapist" means the physical therapist of record who provides either direct or general supervision for a physical therapist assistant or applicant for licensure and delegates components of patient care to that person.

Subchapter 5. Regulation of Practice

435:20-5-1. Display certificate

All persons licensed under Title 59 O.S., Sections 887.1 through 887.17 and practicing in the State shall prominently display the certificate of licensure and evidence of a current renewal in the primary place of practice.

435:20-5-2. Working under supervision

Recent physical therapist or physical therapist assistant graduates who have completed eligibility requirements for examination and submitted all required forms and fees for examination may work in a Physical Therapy facility under the direct, on the premises, supervision and direction of a licensed Physical Therapist.

435:20-5-3. Aiding and abetting the unlicensed practice

It shall be unlawful for any person to aid or abet, directly or indirectly, the practice of physical therapy by any person not duly authorized under the laws of Oklahoma.

435:20-5-8. Unprofessional conduct – Grounds for disciplinary action

- (a) The Physical Therapy Advisory Committee may recommend to the Board to revoke or take other disciplinary action against a licensee or deny a license to an applicant for unprofessional conduct.
- (b) Acts that constitute unprofessional conduct include, but are not limited to:
 - (1) Procuring aiding or abetting a criminal operation.
 - (2) Habitual intemperance or the habitual use of habit-forming drugs.

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- (3) Been convicted of a felony crime that substantially relates to the occupation of physical therapy or poses a reasonable threat to public safety or of a misdemeanor crime involving moral turpitude of a felony or of any offense involving moral turpitude.
- (4) Dishonorable or immoral conduct that is likely to deceive, defraud, or harm the public.
- (5) Aiding or abetting, directly or indirectly, the practice of physical therapy by any person not duly authorized under the laws of this state.
- (6) Engaging in physical conduct with a patient that is sexual in nature, or in any verbal behavior that is seductive or sexually demeaning to a patient.
- (7) Participation in fraud, abuse and/or violation of state or federal laws.
- (8) Any conduct which potentially or actually jeopardizes a patient's life, health or safety.
- (9) Verbally or physically abusing patients.
- (10) Discriminating in the rendering of patient care.
- (11) Negligence while in practice of physical therapy or violating the "Standards of Ethics and Professional Conduct" adopted by the Board.
- (12) Habitual intemperance or addicted use of any drug, chemical or substance that could result in behavior that interferes with the practice of physical therapy and the responsibilities of the licensee.
- (13) Unauthorized possession or use of illegal or controlled substances or pharmacological agents without lawful authority or prescription by an authorized and licensed independent practitioner of the State of Oklahoma.
- (14) Fraudulent billing practices and/or violation of Medicare and Medicaid laws or abusive billing practices.
- (15) Improper management of medical records, inaccurate recording, falsifying or altering or failing to complete documentation of patient records.
- (16) Falsely manipulating patient's records or forging a prescription for medication/drugs, or presenting a forged prescription.
- (17) Aiding, abetting or assisting any other person to violate or circumvent any law, rule or regulation intended to guide the conduct of a physical therapist or physical therapist assistant.
- (18) Being judged mentally incompetent by a court of competent jurisdiction.
- (19) Failing to timely make application for license renewal.
- (20) Falsifying documents submitted to the Physical Therapy Committee or the Oklahoma State Board of Medical Licensure and Supervision.
- (21) Obtaining or attempting to obtain a license, certificate or documents of any form as a physical therapist or physical therapist assistant by fraud or deception.
- (22) Cheating on or attempting to subvert the national physical therapy examination or skills assessment tests.

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- (23) Leaving a patient care assignment without properly advising the appropriate personnel.
 - (24) Violating the confidentiality of information or knowledge concerning a patient.
 - (25) While engaged in the care of a patient, engaging in conduct with a patient, patient family member, or significant other that is seductive or sexually demeaning/exploitive in nature.
 - (26) Failure to report through proper channels the unsafe, unethical or illegal practice of any person who is providing care.
 - (27) Failure to furnish to the Board, its investigators or representatives, information lawfully requested by the Board.
 - (28) Failure to cooperate with a lawful investigation conducted by the Board.
 - (29) Violation of any provision(s) of the Physical Therapy Practice Act or the rules and regulations of the board or of an action, stipulation, agreement or order of the Board.
 - (32) Failure to report to the Board any adverse action taken against him or her by another licensing jurisdiction (United States or foreign), by any governmental agency, by any law enforcement agency, or by a court for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section.
- (c) A physical therapist or physical therapist assistant who knowingly allows or participates with individual(s) who are in violation of the above will be prohibited from supervising other physical therapy practitioners for so long as the Board deems appropriate, and may themselves be subject to disciplinary action pursuant to their conduct.

435:20-5-9. Standards of Ethics and Professional Conduct

In the conduct of their professional activities, the physical therapist and physical therapist assistant shall be bound by the following ethical and professional principles. Physical therapists and physical therapist assistants shall:

- (1) Respect the rights and dignity of all individuals and shall provide compassionate care.
- (2) Demonstrate behavior that reflects integrity, supports objectivity, and fosters trust in the profession and its professionals.
- (3) Comply with state and/or federal laws that govern and relate to physical therapy practice.
- (4) Exercise sound professional judgment and perform only those procedures or functions in which they are individually competent and that are within the scope of accepted and responsible practice. A physical therapist shall not delegate to a less qualified person any activity that requires the unique skill, knowledge, and judgment of the physical therapist. A physical therapist assistant shall provide selected physical therapy interventions only under the supervision and direction of the evaluating physical therapist. A physical therapist assistant shall make judgments that are commensurate with their education and legal qualifications as a physical therapist assistant.

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- (5) Actively maintain and continually improve their professional competence and represent it accurately.
- (6) Maintain high standards by following sound scientific procedures and ethical principles in research and the practice of physical therapy.
- (7) Seek reasonable remuneration for physical therapy practice.
- (8) Provide and make available accurate and relevant information to patients about their care and maintain patient confidentiality
- (9) May provide information to the public about societal benefits of physical therapy services. A physical therapist may advertise his/her services to the public.
- (10) Refuse to participate in illegal or unethical acts, and shall refuse to conceal illegal, unethical or incompetent acts of others.
- (11) Endeavor to address the health needs of society through pro bono services and/or community health services.
- (12) Respect the rights, knowledge and skills of colleagues and other healthcare professionals.

435:20-5-10. Referrals

- (a) A licensed physical therapist who has received a referral from a person licensed as an allopathic physician, osteopathic physician, physician assistant, dentist, chiropractor or podiatrist may extend or reinstitute physical therapy for the patient named on the referral for a time period not to exceed ninety (90) days after the origination of the referral, unless a longer duration of physical therapy services is requested by the referring health care professional, provided that:
 - (1) the diagnosis or symptom listed on the referral is the same as the reason for the extension or reinstitution of the physical therapy treatment.
 - (2) the referring health care professional is notified of the extension or reinstitution of the treatment within five (5) business days of the date of the extension or reinstitution of the physical therapy treatment; and
 - (3) the patient involved has made or is making sufficient improvement in symptoms or function to warrant the extension or reinstitution of the physical therapy treatment without first being seen or re-evaluated by the referring health care professional.
- (b) The physical therapist may not make a medical diagnosis or diagnosis of disease.
- (c) If the physical therapist determines, based on the physical therapy screening and evaluation, that the patient's condition is outside the scope of the physical therapy practice, the physical therapist may not initiate, extend, or reinstitute treatment and must immediately refer the patient to a licensed health care professional.
- (d) If the physical therapist determines, based on reasonable evidence that appropriate improvement in symptoms or function has not been made within 60 days of the date on the referral, the physical therapist shall consult with or refer the patient back to the health care professional who originated the referral.
- (e) The provisions of paragraphs (a) – (d) of this section do not apply if the patient is receiving physical therapy services pursuant to the Individuals with

Disabilities Education Improvement Act of 2004, as may be amended, and the Rehabilitation Act of 1973, Section 504, as may be amended.

Subchapter 7. Supervision of Physical Therapist Assistants

435:20-7-1. Direction and supervision of Physical Therapist Assistants

(a) Responsible supervision.

(1) Physical therapists have a duty to provide therapy services that protect the public safety and maximize the availability of their services. The physical therapist assistant is the only individual permitted to assist in selected treatment interventions. A physical therapist assistant shall be supervised by a specific physical therapist or group of physical therapists working in the same practice setting or physical facility. A physical therapist assistant may not be supervised by any other person including those licensed in other professions. The physical therapist of record is accountable and responsible at all times for the direction of the actions of the physical therapist assistant when treating his/her patient. When determining the extent of assistance the physical therapist assistant can provide, the physical therapist should consider:

- (A) the physical therapist assistant's experience and skill level
- (B) the patient/client criticality and complexity
- (C) the setting in which the care is being delivered
- (D) the predictability of the patient/client outcomes
- (E) the needed frequency of re-examination

(2) A physical therapist shall not delegate to a less qualified person any service that requires the skill, knowledge and judgment of a physical therapist. For each date of service, a physical therapist shall provide all therapeutic interventions that require the expertise of a physical therapist and shall determine when assistive personnel may be used to provide delivery of services in a safe, effective, and efficient manner for each patient.

(A) A physical therapist assistant shall work under a physical therapist's direct or general supervision. A physical therapist assistant may document care provided without the co-signature of the supervising physical therapist. The physical therapist assistant will respond to acute changes in the patient's physiological state and report these findings promptly to the physical therapist. Contact, or attempts to contact the physical therapist of record, will be documented in the medical record.

(B) A physical therapist and a physical therapist assistant may use physical therapy aides for designated and immediately supervised routine tasks. The physical therapist shall not delegate the same type and level of duties to the physical therapy aide as are delegated to the physical therapist assistant. A physical therapy aide shall work under immediate supervision of the physical therapist or physical therapist assistant who is continuously on-site and present in the facility.

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(b) Patient Care Management. Upon accepting a patient for provision of services, the physical therapist becomes the Physical Therapist of Record for that patient and is solely responsible for managing all aspects of the physical therapy plan of care for that patient. The Physical Therapist of Record shall:

- (1) Perform the initial examination and evaluation
- (2) Establish a plan of care and remain responsible to provide and/or supervise the appropriate interventions outlined in the plan of care.
- (3) Perform the re-examination/re-evaluation of the patient in light of their goals and revision of the plan of care when indicated. This will be performed no less frequently than:
 - (A) every 30 days in acute care, outpatient, inpatient rehabilitation and long-term care settings with documented case consultation no less frequently than every 15 days;
 - (B) every 60 days in home health settings with documented case consultation no less frequently than every 30 days;
 - (C) every 90 days in consultative DDSD with documented case consultation no less frequently than every 45 days;
 - (D) every 10th visit for DDSD for patients under 21 years of age with documented case consultation no less frequently than every 5th visit;
 - (E) every 60 days in educational settings with documented case consultation no less frequently than every 30 days;
- (4) Establish the discharge plan and provide or review the documentation of the discharge summary prepared by the physical therapist assistant.
- (5) A physical therapist's responsibility for patient care management shall include oversight of all documentation for services rendered to each patient, including awareness of fees charged or reimbursement methodology used. A physical therapist shall also be aware of what constitutes unreasonable or fraudulent fees.

(c) Designation of a new Physical Therapist of Record.

In the event that the Physical Therapist of Record can no longer assume these responsibilities, care must be turned over to another physical therapist who will become the new Physical Therapist of Record. The Therapist of Record must make sure that the new Physical Therapist of Record is authorized and qualified to receive the patient, must obtain acceptance from the receiving physical therapist, document the hand-over of the patient and maintain the care and responsibility of the patient until the new Physical Therapist of Record is acknowledged in the documentation.

(d) Designation and responsibilities of Supervising Physical Therapist and Alternate Supervising Physical Therapist. Both the physical therapist and physical therapist assistant are responsible for completion of the Form #5, Verification of Supervision.

- (1) A Form #5, Verification of Supervision must be completed annually for each clinical practice setting in which the physical therapist assistant works, identifying the supervising physical therapist for the physical therapist assistant. The physical therapist assistant will be responsible to

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inquire of their supervising physical therapist(s) or the Board, the number of persons being supervised by that physical therapist. If responsible supervision is not practiced, both the supervising physical therapist and the physical therapist assistant are in violation of this rule. Any revised or new Form #5 for a physical therapist assistant at a clinical practice setting will supersede the existing Form #5 for that setting. A physical therapist assistant will not practice in any clinical setting without the necessary Form #5. It is the responsibility of both physical therapists and physical therapist assistants to notify the Board of any changes to a Form #5 that they have signed.

(2) A physical therapist will not supervise and utilize more than four (4) licensed personnel or applicants for licensure. Only three (3) may be physical therapist assistants or applicants for physical therapist assistant licensure. Any of the four (4) may be applicants for physical therapist licensure. This total is inclusive of all geographic locations or employing agencies.

(3) For each practice setting in which he or she works, the physical therapist assistant and the supervising physical therapists must indicate on the Form #5, Verification of Supervision which of the method of supervision described in (A) or (B) below will be employed in that practice setting.

(A) A physical therapist will provide direct or general supervision of a physical therapist assistant and will be listed on the Form #5 as the supervising physical therapist. In the event that he or she is unable to provide supervision, a supervising physical therapist may:

(i) temporarily delegate the supervision of up to three licensed physical therapist assistants to an alternate supervising physical therapist who agrees to provide consultation to the physical therapist assistant(s) for existing plans of care for a period of time not to exceed thirty (30) days. In this event, a new Form #5 is not required, but the alternate supervising physical therapist must be identified as the Therapist of Record in the documentation.

(ii) designate a new Therapist of Record, as in 435:20-7-1-(c) above, to assume full responsibility of the plan of care who may, if they so chose, delegate to a physical therapist assistant under their supervision as listed on their Form #5.

(B) A group of physical therapists, working in the same practice setting may provide supervision to a physical therapist assistant providing the following conditions are met:

(i) all supervising physical therapists are listed on a Form #5 for the physical therapist assistant.

(ii) the ratio of physical therapists to physical therapists assistants in that practice setting does not exceed the ratio of one (1) physical therapist to three (3) physical therapist assistants or applicants for licensure at any given time.

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(iii) The group director, who must be a licensed physical therapist or physical therapist assistant, is identified and assumes responsibility for accurate information on the Form #5 and the appropriate ratio of physical therapist to physical therapist assistants. The Board may assign disciplinary action to the clinical director or all members of the group for violation of the supervision rules.

(e) Supervision of additional physical therapist assistants. In unique cases, a physical therapist may petition the Chair of the Physical Therapy Committee to receive permission to supervise additional physical therapist assistants or applicants for licensure, but this decision to supervise additional assistive personnel must be reviewed and approved by the committee at the next scheduled meeting.

(f) Limits of practice for the physical therapist assistant.

The physical therapist assistant may not:

- (1) Specify, other than to the Physical Therapist of Record, perform or interpret definitive (decisive, conclusive, final) evaluative and assessment procedures. Definitive evaluation procedures may not be recommended to anyone other than the patient's physical therapist, unless previously approved by the physical therapist.
- (2) Alter overall treatment, goals and/or plan.
- (3) Recommend adaptive equipment, assistive devices, or alterations to architectural barriers to persons other than a physical therapist.
- (4) File discharge documents for permanent record until approved by a physical therapist.
- (5) Perform duties or tasks for which he/she is not trained.

Subchapter 9. Professional Development

435:20-9-2. Professional development requirements for renewal

(b) Effective February 1, 2022, and every two years thereafter, physical therapists will be required to show proof of forty (40) approved contact hours and/or PDU equivalent and Physical Therapist Assistants will be required to show proof of thirty (30) approved contact hours and/or PDU equivalent.

- (1) At least half of the required hours must be professional development coursework.
- (2) Three of the required hours must contain ethics education that includes the APTA Guide for Professional Conduct and the APTA Code of Ethics.
- (3) No professional development hours may be carried over from one compliance period to another.

(c) Any applicant for renewal who cannot meet the requirements for professional development may not renew until deficient professional development units (PDUs) are obtained and verified. Additionally, within the next compliance period the licensee will be required to obtain double the required units of approved PDUs.

(d) Each licensee is responsible for maintaining evidence/proof/record of participation in a professional development experience for a minimum of four

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years, two compliance periods. Copies of such proof shall be submitted to the Board upon request.

435:20-9-3. Professional development categories

(b) Synchronous professional development opportunities.

(1) Synchronous education – Real time participation in a course, workshop or conference.

(2) Presentation of program - A licensee who presents an original professional development program targeted towards peers and other health care professionals may receive professional development credit of 1.5 PDU per contact hour of instruction for the first presentation of this original material. No additional PDU for subsequent presentations within the compliance period.

(3) Post Graduate Studies - Successful completion of post graduate education course work related to physical therapy will be awarded professional development credit of up to 16 PDU for each college credit course based on credit hours, syllabus, and learning objectives.

(c) Asynchronous educational and competence opportunities. For licensees participating in a non-interactive course offered by videotape, satellite transmission, webcast, DVD, or other electronic media, one hour of participation earns one PDU. This method must include a posttest proficiency assessment in order to be accepted.

(d) Other professional development activities

(1) Publication - Writing for professional publication may be awarded professional development credit. Acceptance for publication must occur within the current compliance period. Contact hours will not be approved for repeat publication of the same material. Licensee must present copy of published material to receive credit.

(A) Each published paper/book and/or chapter/or case study will receive fifteen (15) PDUs.

(B) Each published book review will receive of ten (10) PDUS.

(2) Study groups - A series of meetings designed for intense study in a physical therapy related topic. A minimum of four participants and four hours of participation are required for professional development eligibility. Those seeking approval for a group study project shall submit a full description including an outline of the topics and subtopics, references, or copies of the printed materials, a time and place of study, the methods to be used, the number of hours of credit sought, and any other information relevant to the evaluation of the proposed projects. The maximum number of PDUs of this type allowed during a compliance period is 12.

(3) Collaboration with educational programs:

(A) Supervising Physical Therapist or Physical Therapist Assistant students as a clinical instructor.

(i) Continuous direct supervision of students and/or candidates for licensure can earn up to 10 PDUs in this

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category in a compliance period. Forty (40) hours of direct supervision will earn one (1) PDU regardless of the number of students and/or candidates for licensure being supervised.

(ii) The licensee shall submit materials listing the licensee as a clinical instructor with the name of the school/program and the length of time of clinical placement.

(B) Presentations as a guest lecturer for Physical Therapist and Physical Therapist Assistant Programs earns 2 PDU for the first presentation of original material, up to 4 PDU for two presentations of original material in a compliance period. No additional PDU for subsequent presentation may be earned within a compliance period. The licensee shall submit materials including: syllabus, curriculum vitae demonstrating expertise, statement of objectives, and strength of evidence demonstrating references used within last 5 years.

(4) Research/Publication/Presentations

(A) Publication:

(i) Authorship or co-authorship of a book relating to physical therapy earns up to fifteen (15) PDU in a compliance period.

(ii) The licensee must present a copy of published material to receive credit.

(B) Research (published only):

(i) Principal or co-investigator, project director, or research assistant earns five (5) PDU, up to ten (10) PDU in a compliance period, provided a licensee may only earn five (5) PDU for one original publication.

(ii) The licensee shall submit research proposal/abstract, final results and a summary of the licensee's involvement.

(C) Presentations at professional workshops, seminars, conferences related to physical therapy earns 1.5 PDU per contact hour of instruction for the first presentation of original materials. A licensee may not earn additional PDU for subsequent presentations of the same materials within the compliance period. The licensee shall submit materials including: brochures or program, curriculum vitae demonstrating expertise, a statement of objectives and strength of evidence demonstrating references used within last 5 years.

(5) Advanced Training:

(A) Specialty certification. Achievement of an APTA or APTA Section-recognized specialty certification related to physical therapy/Advanced Proficiency for PTA will be awarded ten (10) PDU for initial certification and five (5) PDU for recertification. Credit will be granted for certification obtained with the compliance period in which the certification was granted. The licensee shall submit proof of certification for PDU determination.

(B) Residences/Fellowships. For fellowships conferred by

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organizations credentialed by APTA in a specialty area of the practice of physical therapy, ten (10) PDU shall be awarded for each full year of clinical participation up to a maximum of twenty (20) PDU per compliance period for this activity. (i)The licensee shall submit the certificate conferred on the licensee or evidence that all requirements of the fellowship program have been met. (ii)For completion of a residency program in physical therapy offered by an APTA credentialed organization, ten (10) PDU shall be awarded for each full year of clinical participation, up to a maximum of twenty (20) PDU per compliance period for this activity. (iii)The licensee shall submit the certificate conferred on the licensee or evidence that all requirements of the fellowship program have been met.

(6) Physical Therapy organizations

(A) Participation in the national physical therapy or multidisciplinary organization that includes physical therapy:

(i)Participation as a board member, committee chair, task force member or delegate to a national assembly earns five (5) PDU per position for a maximum of ten (10) PDU.

(ii) The licensee shall submit materials documenting the licensee as a participant (for example minutes) as well as a description of the position and a summary of the licensee's involvement.

(B) Participation in a state physical therapy or multidisciplinary organization that includes physical therapy:

(i)Participation as a voting board member or committee chair earns five (5) PDU per position for a maximum of ten (10) PDU in a compliance period.

(ii)The licensee shall submit materials listing the licensee as a participant (for example minutes) as well as a description of the position and a summary of the licensee's involvement.

(C) Participation in a regional or district physical therapy or multidisciplinary organization that includes physical therapy:

(i)Participation as a district officer earns two (2) PDU per position for a maximum of four (4) PDU in a compliance period.

(ii)The licensee shall submit materials listing the licensee as a participant (for example minutes) as well as a description of the position and a summary of the licensee's involvement.

(D) Membership in the APTA for one year earns one PDU, up to two PDU in a compliance period.

(i)The licensee shall submit membership card or certificate for each year of the compliance period.

(ii) Membership in an APTA section for one year earns one half PDU, up to one PDU in a compliance period. Additional PDU are not awarded for membership in more than one

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section. Section membership is validated by membership card.

(E) Learning opportunities not listed above may be considered for professional development credit but will require pre-approval if submitted by the requested deadline.

(F) Learning opportunities not accepted include but are not limited to:

(i) Regularly scheduled education opportunities provided within an institution, such as: rounds or on-the-job required in-service training such as CPR, blood-borne pathogens, equipment or procedural updates.

(ii) Staff meetings.

(iii) Meetings, workshops or seminars held by personnel with less medical training than registered physical therapists or physical therapist assistants.

(iv) Publications for the lay public.

(v) Presentations to lay groups and non-professionals. (

vi) Teaching personnel, students or staff within one's job requirement.

435:20-9-3.1. Approval of providers

(a) The Board shall approve a provider if it is satisfied that the provider's programs have met the standard set forth in 435:20-9-4(a) of this section.

(b) Once a provider is approved, the professional development activities offered by that organization are approved for credit and no application must be made to the Board for approval.

(c) The provider must submit the course information to the Board for posting on the Board website.

The following organizations are considered approved providers:

(1) Any agency or board responsible for licensing individuals to practice physical therapy in the United States or Canada.

(2) The American Physical Therapy Association (APTA), including any Sections, Academies, credentialed residencies and fellowships and its accrediting subsidiaries.

(3) State Chapters of APTA.

(4) The Federation of State Boards of Physical Therapy (FSBPT) and any accrediting subsidiary.

(5) The International Association for Continuing Education and Training (IACET).

(6) Any providers approved or accredited by the agencies or organizations listed in subparagraphs (1) through (5) of this paragraph.

(7) Physical therapist and physical therapist assistant programs approved by an agency recognized by either the U.S. Department of Education or the Council on Postsecondary Accreditation.

Oklahoma Physical Therapy Practice Act

To read the Oklahoma PT Practice Act in its entirety, go to:
https://www.okmedicalboard.org/physical_therapists/download/288/PT+LAW_11.2022.pdf

887.13. Refusal, suspension or revocation of license

The State Board of Medical Licensure and Supervision may refuse to issue or renew, or may suspend or revoke a license to any person, after notice and hearing in accordance with rules and regulations promulgated pursuant to the Physical Therapy Practice Act and the provisions of the Administrative Procedures Act of the Oklahoma Statutes who has:

1. Practiced physical therapy for workers' compensation claims other than under the referral of a physician, surgeon, dentist, chiropractor or podiatrist duly licensed to practice medicine or surgery, a physician assistant or in the case of practice as a physical therapist assistant, has practiced other than under the direction of a licensed physical therapist;
2. Treated or attempted to treat ailments or other health conditions of human beings other than by physical therapy as authorized by the Physical Therapy Practice Act;
3. Failed to refer patients to other health care providers if symptoms are known to be present for which physical therapy treatment is inadvisable or if symptoms indicate conditions for which treatment is outside the standards of practice as specified in the rules and regulations promulgated by the Board pursuant to the provisions of the Physical Therapy Practice Act;
4. Used drugs, narcotics, medication, or intoxicating liquors to an extent which affects the professional competency of the applicant or licensee;
5. Been convicted of a felony or of a crime involving moral turpitude;
6. Obtained or attempted to obtain a license as a physical therapist or physical therapist assistant by fraud or deception;
7. Been grossly negligent in the practice of physical therapy or in acting as a physical therapist assistant;
8. Been adjudged mentally incompetent by a court of competent jurisdiction and has not subsequently been lawfully declared sane;
9. Been guilty of conduct unbecoming a person licensed as a physical therapist or physical therapist assistant or guilty of conduct detrimental to the best interests of the public or the profession;
10. Been guilty of any act in conflict with the ethics of the profession of physical therapy;
- or
11. Had a license suspended or revoked in another state

887.17. Referrals by physicians and surgeons - Agents - Exceptions

A. 1. Except for workers compensation claims, any person licensed under the Physical Therapy Practice Act as a physical therapist shall be able to evaluate and treat human ailments by physical therapy on a patient without a referral from a licensed health care practitioner for a period not to exceed thirty (30) days. Treatment may be provided by a physical therapist assistant under the supervision of a physical therapist. Any treatment provided beyond the thirty-day period shall be only under the referral of a person licensed as a physician or surgeon with unlimited license, or the physician assistant of the person so licensed, and Doctors of Dentistry, Chiropractic and Podiatry, with those referrals being limited to their respective areas of training and practice.

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2. A physical therapist may provide services within the scope of physical therapy practice without a physician referral to children who receive physical therapy services pursuant to the Individuals with Disabilities Education Improvement Act of 2004, as may be amended, and the Rehabilitation Act of 1973, Section 504, as may be amended. Provided further, a plan of care developed by a person authorized to provide services within the scope of the Physical Therapy Practice Act shall be deemed to be a prescription for purposes of providing services pursuant to the provisions of the Individuals with Disabilities Education Improvement Act of 2004, as may be amended, and Section 504 of the Rehabilitation Act of 1973, as may be amended.
 3. Nothing in the Physical Therapy Practice Act shall prevent a physical therapist from performing screening and educational procedures within the scope of physical therapy practice without a physician referral.
 4. Nothing in the Physical Therapy Practice Act shall prevent a physical therapist from performing services that are provided for the purpose of fitness, wellness, or prevention that is not related to the treatment of an injury or ailment.
 5. Nothing in the Physical Therapy Practice Act shall be construed as authorization for a physical therapist or physical therapist assistant to practice any branch of the healing art.
 6. Any person violating the provisions of the Physical Therapy Practice Act shall be guilty of a misdemeanor as per Section 887.16 of this title.
- B. 1. The provisions of the Physical Therapy Practice Act are not intended to limit the activities of persons legitimately engaged in the nontherapeutic administration of baths, massage, and normal exercise.
2. The Physical Therapy Practice Act shall not prohibit students who are enrolled in schools of physical therapy approved by the State Board of Medical Licensure and Supervision from performing such work as is incidental to their course of study; nor shall it prevent any student in any recognized school of the healing art in carrying out prescribed courses of study; provided such school is a recognized institution by the statutes of Oklahoma, and its practitioners are duly licensed as prescribed by law.
 3. Nothing in the Physical Therapy Practice Act shall apply to any person employed by an agency, bureau, or division of the federal government while in the discharge of official duties, however, if such individual engages in the practice of physical therapy outside the line of official duty, the individual must be licensed as herein provided.

Ethics Case Studies

Case Study #1 - Confidentiality

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

Is this a breach in confidentiality?

The information contained in each patient's medical record must be safeguarded against disclosure or exposure to nonproprietary individuals. The right to know

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

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

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

Case Study #2 – Qualifications of Practice

You work in very busy outpatient rehab clinic. One of your coworkers is a physical therapy aide who has worked in rehabilitation for more than 20 years. Frequently, she is called upon to perform treatments that should be done by a PT or PTA. The patients always give her compliments, and frequently request her to treat them. She demonstrates exceptional skills and achieves outstanding outcomes.

Is the clinic providing ethical care to its patients?

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

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

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Case Study #3 – Informed Consent

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

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

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

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

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

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

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

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

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

Case Study #4- Medical Necessity

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

Is limiting care in this manner ethical?

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

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

Case Study #5 – Conflicts of Interest

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

Does this represent a conflict of interest?

Yes, there exists a conflict of interest in this situation. Debi has two primary obligations to fulfill. The first is to her patient. It is her professional duty to recommend to her patient a brace that, in her judgment, will benefit them the most. The second obligation is to her employer, the hospital. As an employee of the hospital, it is her responsibility to manage expenses by thoroughly and objectively seeking effective products that also demonstrate economic efficiency. The conflict of interest occurs when she begins to accept compensation from the vendor in direct or indirect response for her brace orders. Even if she truly believes it is the best brace for her patient, and it is the most cost-effective brace the hospital could purchase, by accepting the money she has established at least an apparent conflict of interest. Under this situation she is obligated to disclose to all parties her financial interest in ordering the braces. This disclosure is necessitated because the potential for personal gain would make others rightfully question whether her objectivity was being influenced.

A conflict of interest is a situation in which a person has a private or personal interest that influences the objective exercise of his or her professional duties. As a professional you take on certain responsibilities and obligations to patients, employers, and others. These obligations must take precedence over a therapist's private or personal interests. In addition to avoiding all real instances of conflict of interest, therapists must also avoid any apparent or potential conflicts as well.

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

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

and employers, but they also damage the whole profession by reducing the trust people generally have in therapists.

Case Study #6 – Relationships with Referral Sources

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

Is this an ethical arrangement?

No, this agreement is not ethical. The most notable infraction involves offering to designate the physician as Medical Director contingent upon the number of referrals he sends. It is perfectly acceptable (and required in some instances) to have a physician as a Medical Director; however, compensating the Medical Director based on their referral volume is unethical. The arrangement described in this case study is undeniably a direct offer of cash for patients. Another area of concern is the rent. At first glance, the rent amount of \$17/sq ft seems fair because it was a compromise between the two parties. However, closer scrutiny reveals this to be unethical. The fair market value for rent has been established as \$20/ft. (Larry's current rental agreement with his landlord) By discounting the doctor \$3/sq ft on his rent, Larry is giving a referral source something of value.

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

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1. _____ is the theory that proposes ethical behavior is a result of developed or inherent character traits. (p. 4-5)
 - A. Utilitarianism
 - B. Social Contract Theory
 - C. Ethical Intuitionism
 - D. Virtue Ethics
2. Which of the following statements is TRUE? (p. 5-6)
 - A. All actions that are legal are also morally right.
 - B. All actions that are morally right are also legal.
 - C. Physical therapy ethics vary state by state.
 - D. The APTA Code of Ethics establishes ethical behavior for all physical therapists; including therapists who are not members of the APTA.
3. Which of the following is NOT one of the Commitments of the APTA's Code of Ethics? (p.6-15)
 - A. Compassion and Trust
 - B. Financial Ascendancy
 - C. Professional Expertise
 - D. Societal Responsibility
4. As per the principles of the APTA's Code of Ethics, it is unethical for a physical therapist to have a sexual relationship with _____. (p.6-15)
 - 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 APTA's Code of Ethics, physical therapist assistants shall provide physical therapy services under the direction and supervision of a _____. (p. 6-15)
 - 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. The primary goal of the informed consent process is to _____. (p. 16)
 - A. Provide protection for health care providers against litigation.
 - B. Ensure that patients have an opportunity to be informed participants in decisions about their health.
 - C. Improve efficiency and accuracy throughout the health care system.
 - D. Facilitate the practice of evidence-based medicine.
7. PT professionals are expected to make a “fiduciary” commitment to their patients. This means that they will _____. (p.19)
 - A. Place the needs and interests of their patients before their own.
 - B. Provide only evidence-based care.
 - C. Charge the patient based only on their ability to pay.
 - D. Provide pro bon services.
8. Gifts from companies to PTs are acceptable only when _____. (p. 21-22)
 - A. the primary purpose is the enhancement of patient care and medical knowledge.
 - B. each professional in the field receives the same gift without regard to previous product usage.
 - C. the company is introducing a new product or service to the market.
 - D. permission is received from the professional’s employer
9. Which profession is NOT identified as an acceptable referral source for physical therapy services? (p. 27)
 - A. Physician Assistant
 - B. Nurse Practitioner
 - C. Dentist
 - D. Podiatrist
10. Which statement is FALSE concerning Oklahoma licensed PTAs? (p. 28-29)
 - A. A PTA must be supervised by a specific physical therapist or group of physical therapists working in the same practice setting or physical facility.
 - B. A physical therapist assistant may document care provided without the cosignature of the supervising physical therapist.
 - C. PT Aides may work under the general supervision of a PTA
 - D. Physical therapist assistants may not recommend adaptive equipment or assistive devices to anyone other than a physical therapist.
11. A Verification of Supervision (Form #5) must be completed annually for each clinical practice setting in which the PTA works. (p. 29-30)
 - A. True
 - B. False

Ethics - Oklahoma Physical Therapy

12. Which of the following is FALSE regarding the professional development requirements for OK licensed physical therapy professionals? (p. 31-32)
- A. At least half of the total required hours must be professional development coursework.
 - B. Three hours of ethics education is required each two-year licensure period.
 - C. No continuing education hours may be carried over from one compliance period to another.
 - D. Each licensee is responsible for maintaining evidence/proof/record of participation in a professional development experience for a minimum of eight years.
13. Oklahoma licensed physical therapists are permitted to provide care for more than 30 days without a physician's referral to which of the following? (p. 36-37)
- A. Children who receive PT services pursuant to the Individuals with Disabilities Education Improvement Act of 2004.
 - B. Individuals in hospice care.
 - C. Residents of long-term skilled nursing facilities.
 - D. Indigent individuals receiving Pro Bono services.
14. Which of the following is applicable for determining conflict of interest? (p.41)
- A. Fiduciary assessment
 - B. Agency benefit
 - C. Trust test
 - D. Universality
15. It is unethical for a physical therapist to _____. (p. 42)
- 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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