

## Ethics & Jurisprudence – Massachusetts Physical Therapy

### Goals & Objectives

#### Course Description

“Ethics and Jurisprudence – Massachusetts Physical Therapy” is an asynchronous text-based online continuing education program for Massachusetts licensed physical therapists and physical therapist assistants. The course focuses on defining moral, ethical, and legal behavior of physical therapy professionals. The information presented includes the APTA’s Code of Ethics, Standards of Ethical Conduct for the PTA, Guide for Professional Conduct for Physical Therapists and Assistants, Massachusetts regulations governing physical therapists (259 CMR 5) and continuing competence (259 CMR 7), model for ethical decision making, and hypothetical case analysis.

#### Course Rationale

This course is designed to educate, promote, and facilitate ethical and legal behavior by Massachusetts licensed physical therapists and physical therapist assistants. It is intended to fulfill the 2-hour ethics, laws, and regulations CE requirement mandated by 259 CMR 7.01(1)

#### Course Goals & Objectives

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

1. define the meaning of ethics and explain the various theories that promote ethical behavior.
2. identify the components of the ethical decision-making model
3. interpret and apply the APTA’s Code of Ethics
4. interpret and apply the APTA’s Standards of Ethical Conduct for the PTA
5. identify and apply the regulations established by Massachusetts 259 CMR 5
6. identify and apply the regulations established by Massachusetts 259 CMR 7
7. differentiate between ethical/unethical and legal/illegal professional behavior in physical therapy practice.

**Course Provider** – Innovative Education Services

**Course Instructor** - Michael Niss, DPT

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

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

**Course Prerequisites** - None

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

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

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

**Course Fee** - \$4.95

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

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

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## Ethics & Jurisprudence – Massachusetts Physical Therapy

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## Ethics Overview

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

Ethics are important on several levels.

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

### Ethics vs. Morals

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

### Ethical Questions

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

## **Ethics Theories**

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

### **Utilitarianism**

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

### **Social Contract Theory**

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

### **Deontological or Duty Theory**

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

### **Ethical Intuitionism**

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

### **Ethical Egoism**

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

### **Natural Law Theory**

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

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

### **Virtue Ethics**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## APTA Code of Ethics

### Preamble

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

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

This Code of Ethics is built upon the five roles of the physical therapist (management of patients/clients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal).

Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist. Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments, activity limitations, participation restrictions, and disabilities to facilitate greater independence, health, wellness, and enhanced quality of life.

### Principles

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

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

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

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

**Principle #2:**

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

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

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

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

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

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

**Principle #3:**

*Physical therapists shall be accountable for making sound professional judgments.*

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

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

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

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

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

**Principle #4:**

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

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



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

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

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

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

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

**Principle #5:**

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

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

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

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

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

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

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

**Principle #6:**

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

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

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

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

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

**Principle #7:**

*Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society.*

7A. Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.

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

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

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

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

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

**Principle #8:**

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

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

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

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

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

**APTA's Guide for Professional Conduct**

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

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

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

### **Respect**

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

### **Altruism**

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

### **Patient Autonomy**

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

### **Professional Judgment**

Principles 3, 3A, and 3B state that it is the physical therapist's obligation to exercise sound professional judgment, based upon his/her knowledge, skill, training, and experience. Principle 3B further describes the physical therapist's judgment as being informed by three elements of evidence-based practice.

With regard to the patient/client management role, once a physical therapist accepts an individual for physical therapy services, he/she is responsible for: the examination, evaluation, and diagnosis of that individual; the prognosis and intervention; re-examination and modification of the plan of care; and the maintenance of adequate records, including progress reports. A physical therapist must establish the plan of care and must provide and/or supervise and direct the appropriate interventions. Regardless of practice setting, a physical therapist has primary responsibility for the physical therapy care of a patient and must make independent judgments regarding that care consistent with accepted professional standards.

If the diagnostic process reveals findings that are outside the scope of the physical therapist's knowledge, experience, or expertise or that indicate the need for care outside

the scope of physical therapy, the physical therapist must inform the patient/client and must refer the patient/client to an appropriate practitioner.

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

### **Supervision**

Principle 3E describes an additional circumstance in which sound professional judgment is required; namely, through the appropriate direction of and communication with physical therapist assistants and support personnel.

### **Integrity in Relationships**

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

### **Reporting**

When considering the application of "when appropriate" under Principle 4C, it is important to know that not all allegedly illegal or unethical acts should be reported immediately to an agency/authority. The determination of when to do so depends upon each situation's unique set of facts, applicable laws, regulations, and policies. Depending upon those facts, it might be appropriate to communicate with the individuals involved. Consider whether the action has been corrected, and in that case, not reporting may be the most appropriate action. Note, however, that when an agency/authority does examine a potential ethical issue, fact finding will be its first step. The determination of ethicality requires an understanding of all of the relevant facts but may still be subject to interpretation.

### **Exploitation**

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

### **Colleague Impairment**

The central tenet of Principles 5D and 5E is that inaction is not an option for a physical therapist when faced with the circumstances described. Principle 5D states that a physical therapist shall encourage colleagues to seek assistance or counsel while Principle 5E addresses reporting information to the appropriate authority.

5D and 5E both require a factual determination on your part. This may be challenging in the sense that you might not know, or it might be difficult for you to determine whether someone in fact has a physical, psychological, or substance-related impairment. In addition, it might be difficult to determine whether such impairment may be adversely affecting his or her professional responsibilities. Moreover, once you do make these

determinations, the obligation under 5D centers not on reporting, but on encouraging the colleague to seek assistance. However, the obligation under 5E does focus on reporting. But note that 5E discusses reporting when a colleague is unable to perform, whereas 5D discusses encouraging colleagues to seek assistance when the impairment may adversely affect his or her professional responsibilities. So, 5D discusses something that may be affecting performance, whereas 5E addresses a situation in which someone is clearly unable to perform. The 2 situations are distinct. In addition, it is important to note that 5E does not mandate to whom you report; it gives you discretion to determine the appropriate authority.

### **Professional Competence**

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

### **Professional Growth**

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

### **Charges and Coding**

Principle 7E provides that the physical therapist must make sure that the process of documentation and coding accurately captures the charges for services performed.

### **Pro Bono Services**

The key word in Principle 8A is "or". If a physical therapist is unable to provide pro bono services, he or she can fulfill ethical obligations by supporting organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

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

### **Standards**

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

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

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

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

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**Standard #2:**

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

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

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

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

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

**Standard #3:**

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

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

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

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

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

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

**Standard #4:**

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

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

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

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

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

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

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

**Standard #5:**

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

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

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

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

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

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

**Standard #6:**

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

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

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

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

**Standard #7:**

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

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

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

**Standard #8:**

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

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

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

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

**Sound Decisions**

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

**Supervision**

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

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### **Clinical Competence**

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

### **Documenting Interventions**

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

## **Informed Consent**

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

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

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

### **Consent for Multiple Treatments**

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

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

### **Blanket Consent**

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

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

### **Notification versus Consent**

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

### **Refusing Treatment**

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

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

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

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

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

### **Resisting Treatment**

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

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

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

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

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

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

## **Relationships**

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

### **Professionalism**

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

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

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

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

### **Boundaries**

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

### **Legal Aspects**

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

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

### **Other Problematic Relationships**

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Confidentiality**

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

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

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

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

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

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



## Massachusetts 259 CMR 5.00: Physical Therapists

### 5.02: Patient Care Management

#### (1) Responsibilities of Physical Therapists.

(a) For each patient on each date of service, a physical therapist shall provide:

1. All of the therapeutic intervention that requires the expertise of a physical therapist and shall determine the appropriate utilization of physical therapist assistants or Physical Therapy Aides that provide for the delivery of care that is safe, effective and efficient. Documentation in the patient record of any considerations, treatment and changes in patient care.
2. Primary responsibility for communication with the patient and sole responsibility for obtaining informed consent prior to initiating intervention.
3. Primary responsibility for physical therapy care rendered by the physical therapist assistant or supportive personnel rests with the Physical Therapist of Record or another physical therapist accessible and willing to assume the responsibility or direction of care for that patient and is documented as such.

(b) A Physical Therapist of Record or another physical therapist accessible and willing to assume the responsibility or direction of care for that patient must be on call and readily available when physical therapy services are being provided by a physical therapist assistant.

(c) All components of clinical care, and their supporting documentation, are the sole responsibility of the physical therapist. These include:

1. Complete an initial clinical examination.
2. Determine a PT diagnosis and PT prognosis.
3. Develop a Plan of Care which is based on the initial clinical examination. The Plan of Care should include:
  - a. identified precautions, special problems, contraindications to care;
  - b. interventions and anticipated progress;
  - c. goals;
  - d. type, amount, frequency and duration of intervention and care; and
  - e. plan for reevaluations and discharge.
4. Designate modes of written and oral communication regarding course of care.
5. Select, delegate and direct appropriate tasks in the Plan of Care to a physical therapist assistant. Decisions should be based on, but not limited to, the following considerations:
  - a. the physical therapist assistant's education, training, experience and skill level;
  - b. the patient's acuity, stability, and complexity; and
  - c. the setting in which the care is being delivered.
6. Perform reexaminations and document findings when a change in the Plan of Care is needed, prior to any planned discharge, and in response to a change in the patient's medical status.

7. Summarize patient's status and document reason for discharge. Ensure safe and quality care at all times and, in those situations in which a physical therapist assistant provides patient care, serve as the supervising physical therapist.
  8. Serve as the only supervisor of physical therapist assistants.
  9. Determine the frequency and amount of supervision of the physical therapist assistant by regularly consulting with the physical therapist assistant to discuss the needs of the patient and the needs of the physical therapist assistant and by utilizing the following factors: a. professional judgment; b. the number of physical therapist assistants the physical therapist can safely and effectively supervise. In the absence of evidence to the contrary, the Board will presume that a ratio that exceeds one physical therapist to three physical therapist assistants is not safe and effective; c. the complexity of the patient's status; and d. the competence of the physical therapist assistant.
  10. Provide supervision to the physical therapist assistant, including at a minimum:
    - a. on-site reexamination of the Patient;
    - b. on-site review of the Plan of Care with appropriate revision or termination;
    - c. evaluation of need and recommendation for utilization of outside resources; and d. availability via verbal communication to the physical therapist assistant while the physical therapist assistant is treating Patient.
  11. Provide direct supervision to the following persons rendering physical therapy services: a. Physical Therapy Students, interns and Physical Therapy Co-op Students; and b. Physical Therapy Assistant Students.
  12. Co-sign the documentation of Physical Therapy Students and Co-op Students or Physical Therapy Assistant Students.
- (2) Responsibilities of Physical Therapist Assistants.
- (a) Work under the supervision of a licensed physical therapist.
  - (b) Cannot initiate a treatment program without prior evaluation and the development of a Plan of Care by the Physical Therapist of Record.
  - (c) Assume the following duties and documentation responsibilities:
    1. Examine and treat the patient based on the patient's current status and the Plan of Care established by the Physical Therapist of Record;
    2. Respond to inquiries regarding the patient status within the protocol established by the Physical Therapist of Record;
    3. Adjust a specific treatment procedure in accordance with changes in patient status within the Plan of Care designed by the Physical Therapist of Record or another physical therapist accessible and willing to assume the responsibility or direction of care for that patient;
    4. Interpret data within the scope of their physical therapist assistant education;

5. Alert the Physical Therapist of Record or another physical therapist accessible and willing to assume the responsibility or direction of care for that patient of a change in patient's status or plateaus in the course of care;
6. Refer inquiries regarding patient prognosis to the Physical Therapist of Record or another physical therapist accessible and willing to assume the responsibility or direction of care for that patient; and
7. Provide direct supervision to the following persons rendering physical therapy services:
  - a. Physical Therapy Assistant Students; and
  - b. Physical Therapy Aides, rehabilitation aides, or other unlicensed personnel.

(3) Responsibilities of Physical Therapy Aides and Non-physical Therapy Co-operative Education Students.

- (a) Work under the direct supervision of a physical therapist or physical therapist assistant
- (b) Perform only non-skilled activities such as:
  1. Ambulation and activity programs for endurance established by the physical therapist and previously completed by the patient requiring the presence of an aide for patient safety.
  2. Exercise programs established by the physical therapist and previously completed by the patient.
  3. Preparation of the patient environment, equipment, or modality for the physical therapist or physical therapist assistant.
    - a. Non-treatment related activities such as secretarial, housekeeping, patient transport; and
    - b. Application of superficial heat and cold.

(4) Responsibilities of Physical Therapy Co-operative Students.

- (a) Work under the direct supervision of a physical therapist.
- (b) The PT Co-op Student shall only carry out those duties contained in 259 CMR 5.02(1)(c) and (2)(c) in which the Physical Therapy Co-op Student has been educated and deemed competent by the academic institution and pursuant to the agreement between the academic institution, the work site, and the student, and delegated to them by the physical therapist directly supervising them.
- (c) PT Co-op Students may also perform those duties listed for a Physical Therapy Aide.

(5) Responsibilities of Physical Therapy Students.

- (a) Work under the direct supervision of their Clinical Instructor (CI) and perform only those duties contained in 259 CMR 5.02(1)(c) as are appropriate.
- (b) Have all notes co-signed by their CI.

- (6) Responsibilities of Physical Therapist Assistant Students. (a) Work under the direct supervision of a licensed physical therapist or physical therapist assistant. (b) Have all notes co-signed by the supervising physical therapist or physical therapist assistant.

**5.03: Assessment and Documentation of PT Treatment Program**

(1) A physical therapist shall document, date, and authenticate the patient's clinical examination, evaluation, diagnosis, prognosis, progress, and any clinical assessment of the patient's condition which results in an alteration in the patient's Plan of Care.

(2) This documentation shall be contained in the patient's ongoing treatment notes or in a formal review of the Plan of Care (or reevaluation). If by formal review of the Plan of Care (or reevaluation), it must be completed in the particular work setting by a Physical Therapist of Record within the following timeframes:

- (a) Acute care: at least every seven to ten days.
- (b) Outpatient, rehabilitation, home health, skilled nursing facility: at least every 30 days.
- (c) Long term chronic care facility and educational school setting: at least every 90 days.

(3) When care is rendered by a physical therapist assistant or Physical Therapy Assistant Student, the documentation shall be contained in the patient's ongoing treatment note.

(4) A physical therapist, Physical Therapy Student, physical therapist assistant and Physical Therapy Assistant Student providing physical therapy intervention(s) shall legibly document, date, and authenticate all care that is provided:

- (a) Using their name as appearing on their professional license or legal name if a student;
- (b) Professional designation as outlined in 259 CMR 5.04; and
- (c) Their license number if applicable.

(5) The supervising physical therapist shall co-sign all documentation provided by physical therapy students.

(6) The supervising physical therapist or physical therapist assistant shall co-sign all documentation provided by Physical Therapy Assistant Students.

(7) Physical therapist assistants are not required to have their documentation co-signed; however, Physical Therapy Students and Physical Therapy Assistant Students must have their notes co-signed by their Clinical Instructor (CI).

(8) Persons practicing pursuant to M.G.L. c. 112, § 23C shall have their documentation co-signed by their directing licensee.

(9) Each visit or patient encounter must be documented, including at a minimum:

- (a) Current patient status and self-reporting;
- (b) Change of status as related to the Plan of Care, if applicable;
- (c) Communication or consultations regarding patient Plan of Care, if applicable;

- (d) Adverse reactions to interventions, if applicable;
  - (e) Identification of specific interventions provided (type, amount, frequency, intensity, and duration) as appropriate;
  - (f) Factors that modify intensity or frequency of interventions;
  - (g) Progress on goals with the Plan of Care, if applicable;
  - (h) Equipment provided, if applicable; and
  - (i) Other pertinent information.
- (10) Billing, as a form of documentation, must accurately reflect the documented treatment interventions.

#### **5.04: Designations**

- (1) Physical therapists shall use the initials PT immediately after their name.
- (2) Physical Therapy Students shall use the initials PT/s immediately after their name.
- (3) Physical therapist assistants shall use the initials PTA immediately after their name.
- (4) Physical Therapy Assistant Students shall use the initials PTA/s immediately after their name.
- (5) Physical therapist or physical therapist assistant applicants practicing under the direction of a licensee pursuant to M.G.L. c. 112, § 23C shall use the initials PT/c or PTA/c immediately after their name.

#### **5.05: Code of Ethics, Guide for Professional Conduct and Standards of Practice for Physical Therapy**

- (1) The following documents in their most recently approved form are adopted as the ethical standards of practice.
  - (a) Code of Ethics for the Physical Therapist. The American Physical Therapy Association (APTA) Code of Ethics delineates the ethical obligations of all physical therapists.
  - (b) Standards of Ethical Conduct for the Physical Therapist Assistant. The APTA Standards of Ethical Conduct delineate the ethical obligations of all physical therapist assistants.
  - (c) Guide for Professional Conduct. The APTA Guide for Professional Conduct provides a framework by which physical therapists may determine the propriety of their conduct and is intended to guide the professional development of Physical Therapy Students.
  - (d) Guide for Conduct of the Physical Therapist Assistant. The APTA Guide for Conduct of the Physical Therapist Assistant provides a framework by which physical therapist assistants may determine the propriety of their conduct and is intended to guide the professional development of Physical Therapy Assistant Students.
  - (e) Standards of Practice for Physical Therapy and Criteria for Standards of Practice for Physical Therapy. The APTA Standards for Practice and Criteria for Standards of Practice provide a foundation for assessment of physical therapist practice.

(2) Disclosure. If a physical therapist is involved in an arrangement with a referring source in which the referring source derives income from the physical therapy service, the physical therapist has an obligation to disclose to the patient that the referring source derives income from the provision of the physical therapy service.

(3) Ownership Interest and Referrals.

(a) A physical therapist involved in the private practice of physical therapy to whom a patient is referred by a person licensed or registered under M.G.L. c. 112 who derives income directly or indirectly from the physical therapy services shall file with the Board under separate cover at the time they renew their physical therapist license:

1. A copy of the "Notice of Ownership Interest" containing the names of all persons maintaining an ownership interest in such practice, which notice is required to be posted in a conspicuous space in the office of the physical therapist (M.G.L. c. 112, § 23P½).

2. A report of the number of referrals to such practice during the previous 24-month period by each person licensed under M.G.L. c. 112 who has an ownership in such practice.

(b) Ownership interest shall mean any and all ownership interest including, but not limited to, any membership, proprietary interest, stock interest, partnership interest, co-ownership in any form or any profit sharing arrangement. (M.G.L. c. 112, § 23P½)

(4) Division of Fees. Physical therapists may not directly or indirectly request, receive or participate in the dividing, transferring, assigning, rebating or refunding of an unearned fee or to profit by means of a credit of other valuable consideration such as an unearned commission, discount or gratuity in connection with the furnishing of physical therapy services.

## **259 CMR 7.00: Continuing Competence**

### **7.01: Continuing Competence Requirements**

(1) Licensed physical therapists and physical therapist assistants are required, as a condition of license renewal, to complete a minimum of 24 points of Board recognized activities for maintaining continuing competence during the preceding biennial renewal period. For each renewal period, each physical therapy professional's continuing competency points must include two points in ethics, laws and regulations governing practice in the Commonwealth of Massachusetts, or some combination thereof. For new physical therapy professionals licensed by examination, this continuing competence requirement commences following their first renewal period after initial licensure.

(2) Board-approved continuing competence activities must relate to the science or contemporary clinical practice of physical therapy and to the licensee's current or anticipated professional roles and responsibilities of the following type and variety.

(a) Publication. Published books, chapters of published books and/or articles in peer reviewed journals authored by the physical therapy or occupational therapy professional may be submitted for Board approval. A maximum of 22 of the total 24 points for activities to maintain continuing competence may be credited per book. A maximum of two points may be credited per book chapter or article published in a peer-reviewed journal.

(b) Presentation and Instruction. Presenters and instructors of academic courses, workshops, or seminars.

1. Academic Courses. Faculty may be credited with four points per academic credit awarded by the accredited degree-granting institution of higher education for a course.

2. Continuing Education Courses, Workshops and Seminars. Instructors may be credited one point for activities to maintain continuing competence for each contact hour of the activity taught by the instructor. Such Board-approved instruction and presentation may count towards no more than ten of the required 24 points for activities to maintain continuing competence per renewal period and points will be awarded only for first time instruction and presentation of courses, workshops or seminars.

Subsequent instruction and presentation of courses, workshops or seminars will be awarded ½ the respective value of points.

(c) Academic Coursework. Fully completed academic coursework, by the licensee, from an accredited, degree-granting institution of higher education may be submitted for no more than six of the required 24 points for activities to maintain continuing competence per renewal period, with one point per academic credit awarded by the accredited degree-granting institution of higher education.

(d) Continuing Competence Programs. Fully completed continuing competence programs may be submitted for up to 24 points, one point per contact hour or equivalent as awarded by the provider.

(e) Other continuing competence activities approved by the American Occupational Therapy Association, Inc. or the American Physical Therapy Association may be submitted for no more than six of the required 24 points for activities to maintain continuing competence per renewal period.

(3) Only those continuing competence activities which are completed during the required continuing competence period, 24 months prior to each renewal date, will be acceptable as qualifying continuing competence activities for that period.

(4) All continuing competence activities other than Board approved continuing competence programs set forth in 259 CMR 7.03(2) are subject to approval by the Board.

### **7.03: Verification/Approval of Provider Continuing Competence Programs and Activities**

(1) For a program or activity to be eligible for approval for continuing competence points, the program or activity content shall directly relate to the practice of occupational therapy or physical therapy in the Commonwealth and the

educational objectives shall exceed a basic level of knowledge as it relates to physical therapy or occupational therapy professional practice.

(2) Programs or activities meeting the requirements of 259 CMR 7.03(1) and endorsed or sponsored by the following organizations shall be deemed approved for continuing competence points:

(a) The activity or program is presented or conducted by a graduate or undergraduate physical therapy or occupational therapy school, program or department accredited by the Accreditation Council for Occupational Therapy Education or the Commission on Accreditation in Physical Therapy Education;

(b) The activity or program has been reviewed and approved for continuing competence credit by the Federation of State Boards of Physical Therapy, the American Physical Therapy Association, the American Occupational Therapy Association, Inc., the Board of Certification, Inc., or a state, regional or professional society or association in the field of physical or occupational therapy;

(c) The activity or program has been approved for continuing competence credit by a governmental agency in any other state, province, territory or political subdivision of the United States or Canada which is responsible for the licensure, certification or registration of physical therapists or occupational therapists; or

(d) The activity or program has been reviewed and approved by a local, state or federal governmental health agency, health institution or an accredited community or teaching hospital. The Board may approve other organizations sponsoring or endorsing continuing competence programs or activities by way of policy published on the Board's website.

## Case Studies

### Case Study #1 - Confidentiality

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

*Is this a breach in confidentiality?*

The information contained in each patient's medical record must be safeguarded against disclosure or exposure to nonproprietary individuals. The right to know any medical information about another is always predicated on a sound demonstration of need. Frequently, many individuals require access to



information contained in a patient's medical record. Their right to access this information is limited to only that information which is deemed necessary for them perform their job in a safe, effective, and responsible manner.

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

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

## **Case Study #2 – Qualifications of Practice**

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

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

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

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

### Case Study #3 – Informed Consent

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

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

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

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

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

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

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

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

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

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

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

*Is limiting care in this manner ethical?*

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

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

## Case Study #5 – Conflicts of Interest

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

*Does this represent a conflict of interest?*

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

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

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

How do you determine if you are in a conflict of interest, whether actual, apparent, or potential? The key is to determine whether the situation you are in interferes or is likely to interfere with your independent judgment. A good test is the 'trust test': Would relevant others (my employer, my patients, professional colleagues, or the general public) trust my judgment if they knew I was in this situation. Trust is at the ethical heart or core of this issue. Conflicts of interest involve the abuse, actual or potential, of the trust people have placed in

professionals. This is why conflicts of interest not only injure particular patients and employers, but they also damage the whole profession by reducing the trust people generally have in therapists.

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

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

*Is this an ethical arrangement?*

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

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

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## Ethics & Jurisprudence – Massachusetts Physical Therapy

### Post-Test

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

6. The primary goal of the informed consent process is to \_\_\_\_\_. (p. 17-20)
- A. Provide protection for health care providers against litigation
  - B. Ensure that patients have an opportunity to be informed participants in decisions about their health.
  - C. Improve efficiency and accuracy throughout the health care system.
  - D. Facilitate the practice of evidence-based medicine.
7. PT professionals are expected to make a “fiduciary” commitment to their patients. This means that they will \_\_\_\_\_. (p. 20-22)
- A. Place the needs and interests of their patients before their own.
  - B. Provide only evidence-based care.
  - C. Charge the patient based only on their ability to pay.
  - D. Provide pro bon services.
8. Gifts from companies to physical therapists are acceptable only when \_\_\_\_\_. (p. 22-24)
- A. the primary purpose is the enhancement of patient care and medical knowledge
  - B. each professional in the field receives the same gift without regard to previous product usage
  - C. the company is introducing a new product or service to the market.
  - D. permission is received from the professional’s employer
9. Information relating to \_\_\_\_\_ is considered to be individually identifiable health information that is covered under the Privacy Rule of HIPAA. (p. 24)
- A. An individual’s past present, or future physical or mental health or condition
  - B. The provision of healthcare to the individual
  - C. The past, present, or future payment for the provision of healthcare to the individual
  - D. All of the above
10. Questions 10-19 are specific to MA Regulations. A PT of record (or another PT accessible and willing to assume the responsibility of care for that patient) must \_\_\_\_\_ when PT services are being provided by a PTA. (p. 25)
- A. be on call and readily available
  - B. be on-site
  - C. provide direct supervision
  - D. be within 500 feet proximity
11. The Board (MA Board of Allied Health Professions) presumes that a ratio that exceeds one physical therapist to three physical therapist assistants is not safe and effective. (p. 26)
- A. True
  - B. False



12. Physical therapy aides may work under the direct supervision of either a physical therapist or a physical therapist assistant. (p. 27)
- A. True
  - B. False
13. In a skilled nursing facility, a formal review of the Plan of Care must be performed by the PT of record at least every \_\_\_\_\_. (p. 28)
- A. 7 days
  - B. 10 days
  - C. 30 days
  - D. 60 days
14. Physical therapist assistants are required to have their documentation co-signed. (p. 28)
- A. True
  - B. False
15. If a PT has an arrangement with a referring source in which the referring source derives income from the PT service, the PT must disclose this arrangement to the patient. (p. 30)
- A. True
  - B. False
16. MA licensed PTs & PTAs must complete a minimum of \_\_\_ points of Board recognized continuing competence activities each biennial renewal period. (p. 30)
- A. 15
  - B. 18
  - C. 20
  - D. 24
17. Each renewal period, the continuing competency activities completed by licensees must include \_\_\_ points in MA PT ethics, laws, and regulations. (p. 30)
- A. one
  - B. two
  - C. three
  - D. four
18. Activities directly relating to PT practice that exceed a basic level of knowledge are approved for MA continuing competence points if they have already been approved for PT continuing competence credit by a governmental agency in any other state. (p. 32)
- A. True
  - B. False

19. Which of the following is applicable for determining conflict of interest?

(p. 36)

- A. Fiduciary assessment
- B. Agency benefit
- C. Trust test
- D. Universality

20. It is unethical for a physical therapist to \_\_\_\_\_. (p. 37)

- A. Have a referring physician as a medical director
- B. Sublease office space to a potential referral source
- C. Waive a treatment co-pay for the spouse of a referring physician
- D. Meet with a physician to educate them about new physical therapy techniques and interventions.

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