

## Ethics & Jurisprudence – Massachusetts Physical Therapy

### Goals & Objectives

#### Course Description

"Ethics and Jurisprudence – Massachusetts Physical Therapy" is an asynchronous 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, 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. identify and apply the regulations established by Massachusetts 259 CMR 5
5. identify and apply the regulations established by Massachusetts 259 CMR 7
6. 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

**Course Location** – Cheapceus.com

**Instructional Method** – Asynchronous online media-based course available continuously

**Course Date** - available continuously on-demand

**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.

**Cancellation by the Learner** – Learners may cancel their participation at any time and receive a full refund of all paid fees.

**Cancellation by the Provider** – Registrants for the cancelled activity will be contacted by an IES staff member via phone call or email within 12 hours of the cancellation decision. If the decision to cancel is made less than 14 hours prior to the event, each participant will be contacted no later than 2 hours prior to the scheduled start time of the activity. Registrants will receive a full refund if an activity is cancelled by the Provider. The refund will be processed back to the Registrant within 12 hours of the cancellation.

**Complaint Resolution** – Please call 954-663-4101 (24 hours/day, 7 days/week) to speak with a live customer service agent. Our goal is to work with our customers to resolve all issues to the customer's satisfaction with just one phone call whenever possible.

**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.

Innovative Educational Services

To take the post-test for CE credits, please go to: [www.cheapceus.com](http://www.cheapceus.com)

## Ethics & Jurisprudence – Massachusetts Physical Therapy

### Course Outline

	page
Goals and Objectives	0:00
Course Outline	
Ethics	
Ethics Overview	0:05
Ethics Theories	0:10
Model for Ethical Decision Making	0:15
APTA Code of Ethics	0:20
Informed Consent	0:40
Relationships	0:45
Gifts & Conflict of Interest	0:50
Confidentiality	0:55
Massachusetts PT Laws & Regulations	1:00
259 CMR 5 – Physical Therapists	1:05
5.02: Patient Care Management	1:10
5.03: Assessment and Documentation	1:15
5.04: Designations	1:20
5.05: Code of Ethics	1:25
259 CMR 7 – Continuing Competence	1:35
7.01: Continuing Competence Requirements	
7.03: Approval of Continuing Competence	
Case Studies	1:45
Case Study #1 – Confidentiality	
Case Study #2 – Qualifications of Practice	
Case Study #3 – Informed Consent	
Case Study #4 – Medical Necessity	
Case Study #5 – Conflict of Interest	
Case Study #6 – Relationships with Referral Sources	
References	
Post-Test	2:00

## 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 vision of the American Physical Therapy Association is “transforming society by optimizing movement to improve the human experience.” Our profession’s charge, as we strive to be an inclusive moral community that is diverse and equitable, is to meet the health needs of all people. APTA is a voluntary professional society that strives both to serve APTA members and to support the profession as a whole. Ethical conduct by physical therapists and physical therapist assistants is vital to the standing of the profession.

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

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

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

## **APTA Code of Ethics Overview**

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

The Code serves two purposes:

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

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

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

## **Ethical Principles**

The nine Ethical Commitments for the physical therapy profession build on the ethical principles of autonomy, beneficence, nonmaleficence, justice, veracity, and fidelity, which are the pillars of ethical decision-making. PTs and PTAs should carefully consider, balance, and weigh these commitments within the



context of the situation in making ethical judgments that are in the best interest of the patient or client and society. Members of the physical therapy profession shall abide by the ethical principles of:

**Autonomy**

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

**Beneficence**

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

**Nonmaleficence**

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

**Justice**

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

**Veracity**

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

**Fidelity**

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

**Ethical Commitments and Standards of Conduct**

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

**1. Respect**

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

Standards of Conduct:

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

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

Aspirational Illustrative Examples:

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

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

## **2. Integrity**

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

Standards of Conduct:

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

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

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

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

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

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

Aspirational Illustrative Examples:

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

2.B Physical therapists and physical therapist assistants shall strive to demonstrate integrity in their relationships with patients and clients, families,

colleagues, students, research participants, other health care providers, employers, payers, and the public.

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

### **3. Accountability**

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

Standards of Conduct:

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

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

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

Aspirational Illustrative Examples:

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

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

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

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

### **4. Maintaining Professional Relationships**

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

Standards of Conduct:

- 4.1 Physical therapists and physical therapist assistants shall not abusively exploit persons over whom they have supervisory, evaluative, or other authority (e.g., patients and clients, students, supervisees, research participants, and employees).
- 4.2 Physical therapists and physical therapist assistants shall not engage in any sexual relationship with any of their patients and clients, supervisees, or students.
- 4.3 Physical therapists and physical therapist assistants shall not harass anyone verbally, physically, emotionally, or sexually.
- 4.4 Physical therapists shall provide reasonable notice and information about alternative sources for obtaining care if the physical therapist terminates the provider relationship while the patient or client continues to need physical therapist services.

Aspirational Illustrative Examples:

- 4.A Physical therapists and physical therapist assistants shall avoid initiating or entering into sexual relationships with individuals over whom they have significant influence on patients' and clients' care decisions and should refer patients and clients to other providers if an existing close personal or sexual relationship with such a person might influence or impinge on the integrity of the relationship between the provider and patient or client.
- 4.B Physical therapists and physical therapist assistants shall strive to collaborate with patients and clients to empower them in making decisions about their health care.
- 4.C Physical therapists and physical therapist assistants shall strive to create an inclusive and civil work environment that strives to promote each colleague's sense of belonging.
- 4.D Physical therapists and physical therapist assistants shall strive to, as appropriate, encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

**5. Compassion and Trust**

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

Standards of Conduct:

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

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

Aspirational Illustrative Examples:

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

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

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

## **6. Responsible Business and Organizational Practices**

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

Standards of Conduct:

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

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

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

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

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

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

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

Aspirational Illustrative Examples:

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

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

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

## **7. Direction and Supervision**

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

Standards of Conduct:

7.1 Physical therapists shall ensure that all duties directed to other physical therapy personnel are congruent with the credentials, qualifications, competencies, and legal scope of practice or scope of work of the individual.

7.2 Physical therapist assistants shall provide physical therapist services under the direction and supervision of a physical therapist and shall communicate with the physical therapist when the patient's or client's status requires modification to the established plan of care.

7.3 Physical therapists shall exercise primary responsibility for the supervision of physical therapist assistants and support personnel.

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

7.5 Physical therapist assistants shall take responsibility to communicate in a timely manner to the supervising physical therapist any areas in which they do not have the necessary level of knowledge and skill to practice safely and effectively.

Aspirational Illustrative Example:

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

## **8. Professional Expertise**

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

Standards of Conduct:

Innovative Educational Services

To take the post-test for CE credits, please go to: [www.cheapceus.com](http://www.cheapceus.com)

8.1 Physical therapists shall recognize and practice within the limits of their skills and competence and refer a patient or client to another health care professional when it is in the best interests of the patient or client.

8.2 Physical therapists and physical therapist assistants shall practice consistent with accepted current standards of care.

**Aspirational Illustrative Examples:**

8.A Physical therapists and physical therapist assistants shall strive to develop and maintain competence and exercise appropriate care in using current and emerging technologies, including but not limited to social media and artificial intelligence.

8.B Physical therapists and physical therapist assistants shall strive to engage in professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, health care delivery, and technology.

8.C Physical therapists and physical therapist assistants shall strive to evaluate the strength of evidence and applicability of content presented during professional development activities before integrating the content or techniques into practice, as appropriate to their professional roles.

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

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

**9. Societal Responsibility**

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

**Aspirational Illustrative Examples:**

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

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

9.C Physical therapists and physical therapist assistants shall strive to advocate to reduce health disparities and health care inequities, improve access to health care services, and address the health, wellness, and preventive health care needs of people.

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

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

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

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

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

### **Informed Consent**

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

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

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

### **Consent for Multiple Treatments**

Although consent is always specific, it is not the same as saying that separate consent is always required for every episode of repeated treatment. When the plan of care for a given diagnosis involves repeated treatments or procedures—



for example, a course of diagnostic tests or ongoing therapy—practitioners do not need to obtain consent for each individual episode.

### **Blanket Consent**

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

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

Innovative Educational Services

To take the post-test for CE credits, please go to: [www.cheapceus.com](http://www.cheapceus.com)

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  $\frac{1}{2}$  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.

## References

- American Physical Therapy Association. (2026) Code of Ethics for the Physical Therapy Profession. <https://www.apta.org/apta-and-you/leadership-and-governance/policies/code-of-ethics-for-the-physical-therapy-profession>
- American Physical Therapy Association. (nd). Consensus Statement on Clinical Judgment in Health Care Settings AOTA, APTA, ASHA. <https://www.apta.org/contentassets/a9b4c99d6f504f7390a3a9d15b4c7d55/aptaaotaashaconsensusstatement.pdf>
- American Physical Therapy Association. Professionalism in Physical Therapy: Core Values. <https://www.apta.org/apta-and-you/leadership-and-governance/policies/core-values-for-the-physical-therapist-and-physical-therapist-assistant>
- American Physical Therapy Association. (2023). Recommended Reading for Understanding Ethics in the Profession-The top 10 articles the EJC recommends for PTs, PTAs, and students in 2023. <https://www.apta.org/your-practice/ethics-and-professionalism/recommended-reading-understanding-ethics-profession>
- Bass, J. D., Baum, C. M., & Christiansen, C. H. (2024). Interventions and outcomes: The person-environment-occupation-performance (PEOP) occupational therapy process. In *Occupational Therapy* (pp. 57-79). Routledge.
- Cain, D. M., & Banker, M. (2020). Do Conflict of Interest Disclosures Facilitate Public Trust? *AMA Journal of Ethics*, 22(3), 232-238.
- Dehkordi, F. G., Torabizadeh, C., Rakhshan, M., & Vizeshfah, F. (2024). Barriers to ethical treatment of patients in clinical environments: A systematic narrative review. *Health Science Reports*, 7(5), e2008.
- Delany, C., & Edwards, I. (2024). From Ethical Reasoning to Ethical Action. In *Clinical Reasoning and Decision Making in Physical Therapy* (pp. 47-56). Routledge.
- Haltaufderheide, J., & Ranisch, R. (2024). The ethics of ChatGPT in medicine and healthcare: a systematic review on Large Language Models (LLMs). *NPJ digital medicine*, 7(1), 183.
- Ibrahim, A. M., Abdel-Aziz, H. R., Mohamed, H. A. H., Zaghmir, D. E. F., Wahba, N. M. I., Hassan, G. A., ... & Aboelola, T. H. (2024). Balancing confidentiality and care coordination: challenges in patient privacy. *BMC nursing*, 23(1), 564.
- Jokinen, A., Stolt, M., & Suhonen, R. (2021). Ethical issues related to eHealth: an integrative review. *Nursing ethics*, 28(2), 253-271.
- Karimian, G., Petelos, E., & Evers, S. M. (2022). The ethical issues of the application of artificial intelligence in healthcare: a systematic scoping review. *AI and Ethics*, 2(4), 539-551.
- Kornblau, B., & Burkhardt, A. (2024). *Ethics in rehabilitation: a clinical perspective*. Routledge.
- Liddell, K., Simon, D. A., & Lucassen, A. (2021). Patient data ownership: who owns your health?. *Journal of Law and the Biosciences*, 8(2), Isab023.
- Loosman, I., & Nickel, P. J. (2022). Towards a design toolkit of informed consent models across fields: A systematic review. *Science and engineering ethics*, 28(5), 42.
- Mahmud, H., Islam, A. N., Ahmed, S. I., & Smolander, K. (2022). What influences algorithmic decision-making? A systematic literature review on algorithm aversion. *Technological Forecasting and Social Change*, 175, 121390.
- Olejarczyk, J. P., & Young, M. (2024). Patient rights and ethics. *StatPearls*.
- Pezdek, K., & Dobrowolski, R. (2023). The Ethical Code of Conduct for Physiotherapists—An Axiological Analysis. *International Journal of Environmental Research and Public Health*, 20(2), 1362.
- Pietrzykowski, T., & Smilowska, K. (2021). The reality of informed consent: empirical studies on patient comprehension—systematic review. *Trials*, 22, 1-8.
- Roy, B., Kumar, A., Kumar, A., & Gowda, K. R. (2022). Ethical conflicts among the leading medical and healthcare leaders. *Asia Pacific Journal of Health Management*, 17(1), 165-172.
- Sakeena, S. N., Gulzar, K., Islam, F., & Raza, A. (2021). Ranking of Ethical Issues Related To Practice In Physical Therapy. *Pakistan Journal of Physical Therapy (PJPT)*.
- Tapuria, A., Porat, T., Kalra, D., Dsouza, G., Xiaohui, S., & Curcin, V. (2021). Impact of patient access to their electronic health record: systematic review. *Informatics for Health and Social Care*, 46(2), 194-206.
- Title 259 Code of Massachusetts Regulations 5.00 – Physical Therapists. Accessed January 29, 2026
- Title 259 Code of Massachusetts Regulations 7.00 – Continuing Competence. Accessed January 29, 2026
- Wu, Z., Xuan, S., Xie, J., Lin, C., & Lu, C. (2022). How to ensure the confidentiality of electronic medical records on the cloud: A technical perspective. *Computers in biology and medicine*, 147, 105726.

**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 Commitments of the APTA's Code of Ethics? (p. 8)
  - A. Compassion and Trust
  - B. Financial Ascendancy
  - C. Professional Expertise
  - D. Societal Responsibility
4. As per the principles of the APTA's Code of Ethics, it is unethical for a physical therapist to have a sexual relationship with \_\_\_\_\_. (p.11-12)
  - A. their patient
  - B. a PTA working under their supervision
  - C. their physical therapy student intern
  - D. All of the above
5. According to the APTA's Code of Ethics, PTAs shall provide physical therapy services under the direction and supervision of a \_\_\_\_\_. (p. 14)
  - 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. 16)
- A. Provide protection for health care providers against litigation
  - B. Ensure that patients have an opportunity to be informed participants in decisions about their health.
  - C. Improve efficiency and accuracy throughout the health care system.
  - D. Facilitate the practice of evidence-based medicine.
7. PT professionals are expected to make a “fiduciary” commitment to their patients. This means that they will \_\_\_\_\_. (p. 19-20)
- 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. 21-22)
- A. the primary purpose is the enhancement of patient care and medical knowledge
  - B. each professional in the field receives the same gift without regard to previous product usage
  - C. the company is introducing a new product or service to the market.
  - D. permission is received from the professional’s employer
9. Information relating to \_\_\_\_\_ is considered to be individually identifiable health information that is covered under the Privacy Rule of HIPAA. (p. 23)
- 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. 24)
- 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. 25)
- 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. 26)
- 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. 27)
- 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. 27-28)
- 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. 29)
- 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 29-30)
- 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 29-30)
- 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. 30-31)
- A. True
  - B. False



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

(p. 35)

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

20. It is unethical for a physical therapist to \_\_\_\_\_. (p. 36)

- 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.

C12926g12926r12926t12926