Ethics – California Occupational Therapy

Goals & Objectives

Course Description
"Ethics – California Occupational Therapy" is an asynchronous online continuing education program for California licensed occupational therapists and occupational therapy assistants. The course focuses on defining moral, ethical, and legal behavior of California licensed occupational therapy professionals. The information presented includes discussions on the theoretical basis for ethical decision-making, the Occupational Therapy Code of Ethics, California occupational therapy regulations and hypothetical case studies.

Course Rationale
This course was developed to educate, promote and facilitate ethical and legal behavior by California licensed occupational therapists and occupational therapy assistants.

Course Goals & Objectives
At the end of this course, the participants will be able to:

1. Define the meaning of ethics and recognize the various theories that promote ethical behavior.
2. Apply a systematic approach to ethical decision-making.
3. Recognize the principles of ethical conduct as defined by the established and accepted Occupational Therapy Code of Ethics
4. Assess their current professional practices to ensure ethical conduct
5. Identify relevant California OT rules and regulations that pertain to ethical professional behavior.
6. Apply the concepts of ethical practice to clinical situations to determine appropriate professional ethical behavior.

Course Provider – Innovative Educational Services

Course Instructor - Michael Niss, DPT

Target Audience - Occupational therapists and occupational therapist assistants

AOTA Classification Code for CE Activity - Category 3: Contemporary Issues & Trends

Level of Difficulty – introductory

Course Prerequisites - None

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

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

Continuing Education Credits – 2 hour; .2 AOTA CEU; 2.5 NBCOT PDUs

Fees - $4.95

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

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

Ethics – California Occupational Therapy

Course Outline

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Ethics Overview

The word “ethics” is derived from the Greek word *ethos* (character). In philosophy, ethics defines what is good for the individual and for society and establishes the nature of duties that people owe themselves and one another. Ethics is also a field of human inquiry that examines the bases of human goals and the foundations of “right” and “wrong” human actions that further or hinder these goals.

Why Ethics are Important

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
Utilitarianism is the theory that right and wrong is determined by the consequences. The basic tool of measurement is pleasure or happiness. A morally correct rule is one that provides the greatest good to the greatest number of people.

Social Contract Theory
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.

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. 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 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.

How to Make Right Decisions

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 geopolitical 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 law enforcement officers 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 occupational therapists and occupational therapist assistants, acceptable ethical practice is documented in the AOTA's Code of Ethics. All OTs and OTAs, even those who are not members of the AOTA, are expected to follow the AOTA guidelines because its Code of Ethics has been established as 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.

AOTA Code of Ethics

The Code of Ethics is an AOTA Official Document and a public statement tailored to address the most prevalent ethical concerns of the occupational therapy profession. It outlines Standards of Conduct the public can expect from those in the profession. It should be applied to all areas of occupational therapy and shared with relevant stakeholders to promote ethical conduct. All occupational therapy personnel, including students in occupational therapy programs, are expected to abide by the Principles and Standards of Conduct within this Code. The Principles and Standards of Conduct that are enforceable for professional behavior include (1) Beneficence, (2) Nonmaleficence, (3) Autonomy, (4) Justice, (5) Veracity, and (6) Fidelity.

The AOTA Code of Ethics was updated in 2015 and is available at:
http://www.aota.org/-/media/Corporate/Files/Practice/Ethics/Code-of-Ethics.pdf

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).

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.

Relationships

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

Professionalism

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

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

of the parties is a professional. An individual may have a personal interest that is perfectly acceptable in itself, but conflicts with an obligation the same individual has as a health care professional.

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

Boundaries

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

Legal Aspects

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

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

Other Problematic Relationships

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

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

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

Gifts and Conflict of Interest

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

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

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

If accepting gifts is ethically problematic in these ways, why do health care professional 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.

California Board of Occupational Therapy Regulations
Title 16, Division 39, California Code of Regulations

The following is an edited and abridged version of the California OT regulations. To read the regulations in their entirety, please go to: http://www.bot.ca.gov/board_activity/laws_regs/cc_regulations.shtml#4170

Article 8. Service Delivery Standards
Subsection 4170. Ethical Standards of Practice

A violation of any ethical standard of practice constitutes grounds for disciplinary action. Every person who holds a license, a limited permit issued by the board, or is practicing on a license issued by another state pursuant to sections 901 or 2570.4 of the Code, shall comply with the following ethical standards of practice:

(a) Occupational therapy practitioners shall comply with state and federal laws pertaining to discrimination.

(1) An occupational therapy practitioner shall consider how a client's or patient's economic status, age, ethnicity, race, disability sexual orientation, gender, gender identity, religion, residence, or culture impact health care practices and incorporate these considerations in the provision of his or her services.

(2) An occupational therapist offering free or reduced-fee occupational therapy services shall exercise the same standard of care when providing those services as for full fee services.

(b) Occupational therapy practitioners shall take reasonable precautions to avoid imposing or inflicting harm upon the client or to his or her property.

(1) Occupational therapy practitioners shall not exploit or harm recipients of occupational therapy services, students, research participants, or employees.

(2) Occupational therapy practitioners shall, while a relationship exists as an occupational therapy practitioner, educator, researcher, or supervisor, and within 6 months of termination of occupational therapy services, avoid relationships or associations that include, but are not limited to emotional, physical, psychological, financial, social or activities that interfere with professional judgment and objectivity, including avoiding:

(A) Any sexual relationship or activity, even if consensual, with any recipient of service, including any family member or significant other of the recipient of services, and

(B) Any sexual relationship or activity, even if consensual, with any student, or research participant under direct supervision, and

(C) Bartering for services or establishing any relationship to further one's own physical, emotional, financial, political, or business interests at the expense of the best interests of the recipients of services, or the potential for exploitation and conflict of interest.

(3) This section shall not apply to consensual sexual contact between a licensee and his or her spouse, registered domestic partner, or person in an equivalent domestic relationship, when that licensee provides occupational therapy services to his or her spouse, registered domestic partner, or person in an equivalent domestic relationship.

(c) Occupational therapy practitioners shall collaborate with clients, caretakers or other legal guardians in setting goals and priorities throughout the intervention process.

(1) Occupational therapy practitioners shall fully inform the client of the nature, risks, and potential outcomes of any interventions.

(2) Occupational therapy practitioners shall obtain informed consent from clients involved in research activities and indicate in the medical record that they have fully informed the client of potential risks and outcomes.
(3) Occupational therapy practitioners shall respect the client's right to refuse professional services.
(4) Occupational therapy practitioners shall maintain patient confidentiality unless otherwise mandated by local, state or federal regulations.
(d) Occupational therapy practitioners shall perform occupational therapy services only when they are qualified by education, training, and experience to do so and shall refer to or consult with other service providers whenever such a referral or consultation is necessary for the care of the client. Such referral or consultation should be done in collaboration with the client.
(e) Occupational therapy practitioners shall, through completion of professional development activities required for license renewal or in other ways assure continued competence with respect to his or her own current practice and technology.
(f) Occupational therapy practitioners shall report to the Board any acts committed by another occupational therapy practitioner that they have reason to believe are unethical or illegal in practice, education, research, billing, or documentation, and shall cooperate with the Board by providing information, documentation, declarations, or assistance as may be allowed by law.
(g) Occupational therapy practitioners shall make all other mandatory reporting to the appropriate authorities as required by law.
(h) Occupational therapy practitioners shall comply with the Occupational Therapy Practice Act, the California Code of Regulations, and all other related local, state, and federal laws, and shall comply with the following:
(1) Practice occupational therapy only when holding a current and valid license issued by the board, and appropriate national, state, or other requisite credentials for the services they provide; and
(2) Practice occupational therapy within his or her own level of competence and scope of practice.
(i) Occupational therapy practitioners shall provide accurate information about occupational therapy services and shall accurately represent their credentials, qualifications, education, experience, training, and competence.
(j) Occupational therapy practitioners shall disclose any professional, personal, financial, business, or volunteer affiliations that may pose a conflict of interest to those with whom they may establish a professional, contractual, or other working relationship.
(k) Occupational therapy practitioners shall not use or participate in the use of any form of communication that contains false, fraudulent, deceptive statements or claims.
(l) Occupational therapy practitioners shall report to the Board acts constituting grounds for discipline as defined in Section 2570.28 of the Occupational Therapy Practice Act.

Article 9. Supervision Standards
Definitions

In addition to the definitions found in Business and Professions Code sections 2570.2 and 2570.3 the following terms are used and defined herein:
(a) "Client related tasks" means tasks performed as part of occupational therapy services rendered directly to the client.
(b) "Level I student" means an occupational therapy or occupational therapy assistant student participating in activities designed to introduce him or her to fieldwork experiences and develop an understanding of the needs of clients.
(c) "Level II student" means an occupational therapy or occupational therapy assistant student participating in delivering occupational therapy services to clients with the goal of developing competent, entry-level practitioners.
(d) "Non-client related tasks" means clerical, secretarial and administrative activities; transportation of patients/clients; preparation or maintenance of treatment equipment and work area; taking care of patient/client personal needs during treatments; and assisting in the construction of adaptive equipment and splints.
(e) "Periodic" means at least once every 30 days.

Parameters
(a) Appropriate supervision of an occupational therapy assistant includes, at a minimum:
(1) The weekly review of the occupational therapy plan and implementation and periodic onsite review by the supervising occupational therapist. The weekly review shall encompass all aspects of occupational therapy services and be completed by telecommunication or onsite.
(2) Documentation of the supervision, which shall include either documentation of direct client care by the supervising occupational therapist, documentation of review of the client's medical and/or treatment record and the occupational therapy services provided by the occupational therapy assistant, or co-signature of the occupational therapy assistant's documentation.
(3) The supervising occupational therapist shall be readily available in person or by telecommunication to the occupational therapy assistant at all times while the occupational therapy assistant is providing occupational therapy services.
(4) The supervising occupational therapist shall provide periodic (at least once every 30 days) on-site supervision and observation of client care rendered by the occupational therapy assistant.
(b) The supervising occupational therapist shall at all times be responsible for all occupational therapy services provided by an occupational therapy assistant, a limited permit holder, a student or an aide. The supervising occupational therapist has continuing responsibility to follow the progress of each client, provide direct care to the client, and assure that the occupational therapy assistant, limited permit holder, student or aide do not function autonomously.
(c) The level of supervision for all personnel is determined by the supervising occupational therapist whose responsibility it is to ensure that the amount, degree, and pattern of supervision are consistent with the knowledge, skill and ability of the person being supervised.
(d) Occupational therapy assistants may supervise:

(1) Level I occupational therapy students;
(2) Level I and Level II occupational therapy assistant students; and
(3) Aides providing non-client related tasks.
(e) The supervising occupational therapist shall determine that the occupational therapy practitioner possesses a current license or permit to practice occupational therapy prior to allowing the person to provide occupational therapy services.

Treatments performed by an Occupational Therapy Assistant
(a) The supervising occupational therapist shall determine the occupational therapy treatments the occupational therapy assistant may perform. In making this determination, the supervising occupational therapist shall consider the following:
(1) the clinical complexity of the patient/client;
(2) skill level of the occupational therapy assistant in the treatment technique; and
(3) whether continual reassessment of the patient/client status is needed during treatment. This rule shall not preclude the occupational therapy assistant from responding to acute changes in the client's condition that warrant immediate action. The occupational therapy assistant shall inform the supervising occupational therapist immediately of the acute changes in the patient's/client's condition and the action taken.
(b) The supervising occupational therapist shall assume responsibility for the following activities regardless of the setting in which the services are provided:
(1) Interpretation of referrals or prescriptions for occupational therapy services.
(2) Interpretation and analysis for evaluation purposes.
(A) The occupational therapy assistant may contribute to the evaluation process by gathering data, administering standardized tests and reporting observations. The occupational therapy assistant may not evaluate independently or initiate treatment before the supervising occupational therapist performs an assessment/evaluation.
(3) Development, interpretation, implementation, and modifications of the treatment plan and the discharge plan.
(A) The supervising occupational therapist shall be responsible for delegating the appropriate interventions to the occupational therapy assistant.
(B) The occupational therapy assistant may contribute to the preparation, implementation and documentation of the treatment and discharge summary.

Treatments Performed by Occupational Therapy Limited Permit Holders and Students
(a) Consistent with Code section 2570.4, subdivisions (b) and (c), a Level II student may, at the discretion of the supervising occupational therapy practitioner, be assigned duties or functions commensurate with his or her education and training.
(b) All documented client-related services by the limited permit holder or student shall be reviewed and cosigned by the supervising occupational therapist.

Delegation of Tasks to Aides
(a) The primary function of an aide in an occupational therapy setting is to perform routine tasks related to occupational therapy services. Non-client related tasks may be delegated to an aide when the supervising occupational therapy practitioner has determined that the person has been appropriately trained and has supportive documentation for the performance of the services.
(b) Client related tasks that may be delegated to an aide include specifically selected routine aspects of an intervention session. In addition to the requirements of Code section 2570.2, subdivisions (a) and (b), the following factors must be present when an occupational therapist delegates a selected aspect of an intervention to an aide:
(1) The outcome anticipated for the aspects of the intervention session being delegated is predictable.
(2) The situation of the client and the environment is stable and will not require that judgment or adaptations be made by the aide.
(3) The client has demonstrated previous performance ability in executing the task.
(4) The aide has demonstrated competence in the task, routine and process.
(c) The supervising occupational therapist shall not delegate to an aide the following tasks:
(1) Performance of occupational therapy evaluative procedures;
(2) Initiation, planning, adjustment, or modification of treatment procedures.
(3) Acting on behalf of the occupational therapist in any matter related to occupational therapy treatment that requires decision making.

California Occupational Therapy Practice Act

The following is an edited and abridged version of the Act. To read the Act in its entirety, please go to: www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=02001-03000&file=2570-2571

2570.28. The board may deny or discipline a licensee for any of the following:
(a) Unprofessional conduct, including, but not limited to, the following:
(1) Incompetence or gross negligence in carrying out usual occupational therapy functions.
(2) Repeated similar negligent acts in carrying out usual occupational therapy functions.
(3) A conviction of practicing medicine without a license in violation of Chapter 5 (commencing with Section 2000), in which event a certified copy of the record of conviction shall be conclusive evidence thereof.
(4) The use of advertising relating to occupational therapy which violates Section 17500.
(5) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a licensee by another state or territory of the United States, by any other government agency, or by another California health care

professional licensing board. A certified copy of the decision, order, or judgment shall be conclusive evidence thereof.
(b) Procuring a license by fraud, misrepresentation, or mistake.
(c) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision or term of this chapter or any regulation adopted pursuant to this chapter.
(d) Making or giving any false statement or information in connection with the application for issuance or renewal of a license.
(e) Conviction of a crime or of any offense substantially related to the qualifications, functions, or duties of a licensee, in which event the record of the conviction shall be conclusive evidence thereof.
(f) Impersonating an applicant or acting as proxy for an applicant in any examination required under this chapter for the issuance of a license.
(g) Impersonating a licensed practitioner, or permitting or allowing another unlicensed person to use a license.
(h) Committing any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, or duties of a licensee.
(i) Committing any act punishable as a sexually related crime, if that act is substantially related to the qualifications, functions, or duties of a licensee, in which event a certified copy of the record of conviction shall be conclusive evidence thereof.
(j) Using excessive force upon or mistreating or abusing any patient. For the purposes of this subdivision, "excessive force" means force clearly in excess of that which would normally be applied in similar clinical circumstances.
(k) Falsifying or making grossly incorrect, grossly inconsistent, or unintelligible entries in a patient or hospital record or any other record.
(l) Changing the prescription of a physician and surgeon or falsifying verbal or written orders for treatment or a diagnostic regime received, whether or not that action resulted in actual patient harm.
(m) Failing to maintain confidentiality of patient medical information, except as disclosure is otherwise permitted or required by law.
(n) Delegating to an unlicensed employee or person a service that requires the knowledge, skills, abilities, or judgment of a licensee.
(o) Committing any act that would be grounds for denial of a license under Section 480.
(p) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of infectious diseases from licensee to patient, from patient to patient, or from patient to licensee.
(1) In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Public Health developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, guidelines, and regulations pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 63001) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B,

and other blood-borne pathogens in health care settings. As necessary to encourage appropriate consistency in the implementation of this subdivision, the board shall consult with the Medical Board of California, the Board of Podiatric Medicine, the Dental Board of California, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians.
(2) The board shall seek to ensure that licensees are informed of their responsibility to minimize the risk of transmission of infectious diseases from health care provider to patient, from patient to patient, and from patient to health care provider, and are informed of the most recent scientifically recognized safeguards for minimizing the risks of transmission.

2570.29. In addition to other acts constituting unprofessional conduct within the meaning of this chapter, it is unprofessional conduct for a person licensed under this chapter to do any of the following:
(a) Obtain or possess in violation of law, or prescribe, or, except as directed by a licensed physician and surgeon, dentist, optometrist, or podiatrist, to administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
(b) Use to an extent or in a manner dangerous or injurious to himself or herself, to any other person, or to the public, or that impairs his or her ability to conduct with safety to the public the practice authorized by his or her license, of any of the following:
(1) A controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code.
(2) A dangerous drug or dangerous device as defined in Section 4022.
(3) Alcoholic beverages.
(c) Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in subdivisions (a) and (b) of this section, or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a) of this section, in which event the record of the conviction is conclusive evidence thereof.
(d) Be committed or confined by a court of competent jurisdiction for intemperate use of any of the substances described in subdivisions (a) and (b) of this section, in which event the court order of commitment or confinement is prima facie evidence of the commitment or confinement.
(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital or patient record, or any other record, pertaining to the substances described in subdivision (a) of this section.

2570.36. If a licensee has knowledge that an applicant or licensee may be in violation of, or has violated, any of the statutes or regulations administered by the board, the licensee shall report this information to the board in writing and shall cooperate with the board in providing information or assistance as may be required.

Ethical Case Studies

Case Study #1 - Confidentiality

John Jones OTR, Sue Brown (therapy receptionist), and Mary Smith (Director of Managed Care Contracting), are in a private OT office discussing the fact that they are treating Jessica McDonald, an award winning actress. John says, "I can't believe that I'm actually treating Jessica McDonald." Mary asks, "How bad do you think her injury is?" John replies, "I saw her MRI report, it looks likes she is going to need surgery to repair her wrist."

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 her medical information. Therefore, the disclosure to Mary of the patient's identity and medical information is a breach of patient confidentiality.

Case Study #2 – Informed Consent

Sam Smith OTR has just received orders to begin therapy with a 75-year-old woman who is s/p right humerus ORIF. He goes to her hospital room to evaluate her and begin therapy. 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 using her right arm. The patient refuses. Sam leaves and returns the next day to try again. Again, she declines treatment and he leaves.

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

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

The most important goal of informed consent is that the patient has an opportunity to be an informed participant in their health care decisions. It is generally accepted that complete informed consent includes a discussion of the following elements:

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

In order for the patient's consent to be valid, they must be considered competent to make the decision at hand and their consent must be voluntary. It is easy for coercive situations to arise in medicine. Patients often feel powerless and vulnerable. 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.

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

Case Study #3- Medical Necessity

Steve Smith is an occupational therapist who owns his own therapy clinic. He recently signed a contract with an HMO to provide OT services. The contract stipulates that Steve will be compensated on a case rate basis. (A fixed amount of money based on the patient's diagnosis) Steve has performed a thorough

cost analysis on this contract and has determined that the financial "breakeven" point (revenue equals expenses) for patients with this diagnosis is 5 visits. He informs his staff that all patients covered by this insurance must be discharged by their fourth visit.

Is limiting care in this manner ethical?

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

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

Case Study #4 – Conflicts of Interest

Debi Brown OTR 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 #5 – Relationships with Referral Sources

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

Is this an ethical arrangement?

No, this agreement is not ethical. The most notable infraction involves offering to designate (and compensate) the physician as the Medical Director contingent upon the number of referrals he sends. It is perfectly acceptable (and required in some instances) to have a physician as a Medical Director; however, compensating the Medical Director based on their referral volume is unethical. Another area of concern is the rent. At first glance, the rent amount of $17/sq. ft. seems fair because it was a compromise between the two parties. However, closer scrutiny reveals this to be unethical. The fair market value for rent has been established as $20/sq. 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 an occupational 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.

Supplemental Information

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Ethics – California Occupational Therapy

Post-Test

1. Which ethics theory proposes that right and wrong are determined by consequence? (p. 4)
   A. Utilitarianism
   B. Social Contract Theory
   C. Ethical Egoism
   D. Natural Law Theory

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. Occupational therapy ethics vary state by state.
   D. The AOTA Code of Ethics establishes ethical behavior for all occupational therapists; including those who are not members of the AOTA.

3. Which professional behavior is NOT addressed in the AOTA's Code of Ethics - Principles and Standards of Conduct? (p. 6)
   A. Beneficence
   B. Nonmaleficence
   C. Competence
   D. Veracity

4. The goal of the informed consent process is to _____. (p. 7)
   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 care
   C. improve efficiency and accuracy throughout the health care system
   D. facilitate the practice of evidence based medicine

5. OT professionals are expected to make a "fiduciary" commitment to their patients. This means that they will _____. (p. 8)
   A. place the needs and interests of their patients before their own
   B. provide only evidence-based care
   C. charge the patient based on their ability to pay
   D. provide pro bono services

6. Gifts from companies to OT professionals are acceptable only when ___. (p. 11)
   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

7. Under HIPAA regulations, information related to which of the following is considered “individually identifiable health information”? (p. 12)
   A. An individual’s past, present or future physical or mental health or condition.
   B. Payment for the provision of health care
   C. A patient’s birth date
   D. All of the above

8. A consensual sexual relationship between a California licensed occupational therapy practitioner and a _____ is unethical. (p. 13)
   A. patient currently under the care of the practitioner.
   B. family member of a patient discharged from the practitioner’s care five months ago.
   C. student under direct supervision of the practitioner
   D. All of the above

9. California licensed occupational therapists are required to perform which of the following in order to appropriately supervise an occupational therapy assistant. (p. 15)
   A. On-site supervision of the OTA and observation of client care at least once every 30 days.
   B. A review of the occupational therapy plan at least every 14 days
   C. An in-person re-evaluation of the client every 21 days.
   D. Weekly communication, either in-person or teleconference, with the OTA.

10. Which of the following is unethical? (p. 23-24)
   A. Having a physician serve as your facility’s Medical Director.
   B. Showing your appreciation to your top referral source by giving them NFL season tickets
   C. Taking a case manager out to lunch to inform her about the new therapy services you have available
   D. Subleasing office space to an attorney.

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