

## Ethics – Georgia Occupational Therapy

### Goals & Objectives

#### Course Description

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

#### Course Rationale

This course was developed to educate, promote and facilitate ethical and legal behavior by Georgia licensed occupational therapists and occupational therapy assistants and to meet the Ethics requirements of Georgia Administrative Code 671-3-.08(3)(e).

#### 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 Georgia 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 hours; .2 AOTA CEU; 2.5 NBCOT PDUs

**Fees** - \$9.95

**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 – Georgia 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 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.

## **Georgia Occupational Therapy Rules Georgia Rules & Regulations, Chapter 671**

The following is an edited and abridged version of the Georgia Occupational Therapy Rules.  
To read the Rules in their entirety, please go to: <http://rules.sos.ga.gov/GAC/671>

### **Rule 671-4-.01 Ethics of Occupational Therapy**

Each licensed Occupational Therapist and Occupational Therapy Assistant shall:

1. Adhere to the code of ethics as adopted and published by the Board;
2. Demonstrate concern for the safety and well-being of the recipients of their services and ensure services and fees are provided in a fair and equitable manner;
3. Take measures to ensure each recipient's safety and avoid imposing or inflicting harm, avoid exploitation in any manner in therapeutic relationships, use professional judgment and objectivity at all times, avoid any compromise in the provision of services, and accept responsibility for professional actions;
4. Respect recipients, assuring their rights and observing confidentiality at all times;
5. Strive to achieve and continually maintain high standards of competence and take responsibility for competence through professional development and educational activities;
6. Comply with laws and rules of the State of Georgia and the Georgia State Board of Occupational Therapy, encourage peers to adhere to the Code of Ethics of the profession, and reporting any breaches of the Code of Ethics to the proper authority;
7. Provide accurate and complete information when representing the profession; and
8. Treat all colleagues and other professionals with respect, fairness, discretion and integrity.

### **Rule 671-4-.02 Unprofessional Conduct Defined**

Unprofessional conduct shall include, but not be limited to, the following:

- a) Obtaining or attempting to obtain a license by fraud, misrepresentation, or concealment of material facts;
- b) Violating the ethics of occupational therapy as set forth by the Georgia Board of Occupational Therapy;
- c) Being grossly negligent in the practice of occupational therapy or as an occupational therapy assistant;
- d) Using drugs or intoxicating liquors to the extent that these effect the licensee's professional competence;
- e) Practicing occupational therapy after being adjudged mentally incompetent by a court of competent jurisdiction;
- f) Being convicted of a crime other than minor offenses defined as "minor misdemeanors", "violations" or "offenses" in any court if the acts for which he or she was convicted are found by the Board to have a direct bearing on

- whether he or she should be entrusted to serve the public in the capacity of an occupational therapist or occupational therapy assistant;
- g) Using or holding yourself out as being able to utilize occupational therapy techniques involving physical agent modalities when not certified by the Board to use physical agent modalities;
  - h) Having committed any other conduct which ordinary and reasonable individuals would consider unprofessional.

**Rule 671-2-.02 Supervision Defined**

Supervision as used in the law shall mean personal involvement of the licensed occupational therapist in the supervisee's professional experience which includes evaluation of his or her performance. Further, supervision shall mean personal supervision with weekly verbal contact and consultation, monthly review of patient care documentation, and specific delineation of tasks and responsibilities by the licensed occupational therapist and shall include the responsibility for personally reviewing and interpreting the results of any habilitative or rehabilitative procedures conducted by the supervisee. It is the responsibility of the licensed occupational therapist to ensure that the supervisee does not perform duties for which he or she is not trained. C.O.T.A.s and limited permit holders must be supervised.

**Rule 671-2-.03 Direct Supervision Defined**

Direct Supervision as used in the Law shall mean daily on-site, close contact whereby the supervisor is able to respond quickly to the needs of the client or supervisee. It requires specific delineation of task and responsibilities by a licensed Occupational Therapist and shall include the responsibility for personally reviewing and interpreting the result of any habilitative or rehabilitative procedures conducted by the supervisee. It is the responsibility of the licensed occupational therapist to ensure that the supervisee does not perform duties for which he/she is not trained.

**Rule 671-2-.04 Consultation Defined**

1. For purposes of O.C.G.A. Section 43-28-3(7), consultation shall mean periodic meetings between the licensed occupational therapist and the occupational therapy assistant to review and to provide recommendations and resource information regarding methods of implementation of the occupational therapy programs.
2. For purposes of O.C.G.A. Section 43-28-15(b), consultation shall mean providing advice, resource information, and/or therapy demonstrations to an occupational therapist or occupational therapy assistant licensed in the State of Georgia, provided that any final decisions involving patient care shall be made by the Georgia licensee.

**Rule 671-3-.08 Renewal of License; Continuing Education**

1. A license issued by the Board shall expire on March 31st of even numbered years. The license may be renewed upon submission of the renewal application

and payment of the required fee, provided all requirements have been met. Refer to fee schedule.

2. A license that is not renewed on or before March 31st of the renewal year shall be deemed lapsed. An application for reinstatement shall be required as provided for in Rule 671-3-.09 in order to seek reinstatement of a lapsed license to practice in this State. Practicing with an expired license is prohibited by law and practice during this period may result in disciplinary action for unlicensed practice.

3. Before or on March 31, 2014 and for renewal cycles after that date, the continuing education requirements contained in this rule will be required for the renewal or reinstatement of a license. Except as otherwise provided, each licensee is required to complete during each two (2) year renewal period a minimum of twenty-four (24) continuing education hours prior to the expiration date of the license. Failure to complete continuing education prior to expiration date can result in disciplinary action. Acceptable professional continuing education activities shall include activities relevant to occupational therapy practice that can be deemed to update or enhance knowledge and skills required for competent performance beyond entry level occupational therapy. A continuing education hour is defined as actual time spent in instruction or organized learning experiences excluding meals, breaks, welcome/introductions, and business meetings.

- a. At least fourteen (14) hours of the required twenty-four (24) continuing education hours must be related to direct patient care. This includes occupational therapy assessment, treatment planning, occupational therapy implementation and diagnostic related information.
- b. A maximum of six (6) hours of the required twenty-four (24) continuing education hours can be in "General" continuing education. This includes areas related to administration, supervision, documentation, quality assurance and research.
- c. A maximum of four (4) hours of the required twenty-four (24) continuing education hours may be used for Level II fieldwork supervision, published professional writing and instructional presentations.
- d. Each licensee must complete a minimum of two (2) hours of the required twenty-four (24) continuing education hours in the ethics of occupational therapy practice.
- e. At least twelve (12) of the required twenty-four (24) continuing education hours must be obtained by attendance at live presentations such as workshops, seminars, conferences or formal academic coursework.
- f. A maximum of twelve (12) of the required twenty-four (24) continuing education hours may be obtained by electronic or web based courses, formal self-study courses, satellite broadcasts, computer learning activities, webinars, or viewing videotapes in a professional setting.

4. An individual who is applying for licensure in Georgia for the first time (never having held a Georgia OT or OTA license) and who is licensed during the second year of the biennium renewal period is not required to meet continuing education requirements for that initial renewal period only.

5. Prior approval of continuing education courses is not required. Each licensee randomly selected for a CE audit must submit to the Board supporting documentation as specified in this rule.
6. Procedures for verifying to the Board that the continuing education requirements for licensure renewal have been met:
  - a. Respond appropriately to questions on renewal of license application;
  - b. Retain continuing education documentation in personal files and submit to the Board if selected for a continuing education audit;
  - c. Documentation as specified in this rule must be maintained by the licensee for no less than four (4) years from the beginning date of the licensure period.
7. Documentation of continuing education which the Board deems as acceptable proof of completion includes the following:
  - a. For continuing education courses that include attendance and participation at a live presentation such as a workshop, seminar, conference or in-service educational program:
    1. A certificate of completion or similar documentation signed by program official, and
    2. A program description including sponsor, course title, date(s), program objectives/learning outcomes, content description, and agenda or schedule. A shortened description may be accepted for programs specifically exempted by the Board such as AOTA and GOTA Conferences;
  - b. For "General" continuing education as referenced in this rule, if obtained at a conference, workshop or live presentation, required documentation is as noted above. All other must include:
    1. Explanation of the relationship of the activity to occupational therapy and your professional growth.
    2. Date(s) and clock hours of the activity;
    3. Other information as may be requested.
  - c. For Level II Fieldwork Supervision involving serving as the primary clinical fieldwork educator for Level II occupational therapy or occupational therapy assistant fieldwork students:
    1. A description of the fieldwork including name and type of facility, name of the fieldwork educator and times spent in direct supervision of the student; and,
    2. Verification provided by the school to the fieldwork educator with the name of the student, school and dates of fieldwork or the signature page of the completed student evaluation form with evaluation scores and comments blocked out;
  - d. For published professional writing and instructional presentations, as referenced in this rule, including first time or significantly revised presentations or an academic class session, workshop, seminar, in-service or professional meeting program session:
    1. Presentation description including location, title, date, hours of presentation, general content description, and type of audience; and,

2. Verification of presentation or formal thank you note signed by the sponsor or program official.
- e. Documentation of electronic or web based course, formal self-study courses, satellite broadcasts, computer learning activities or viewing of videotapes in a professional setting must include:
  1. Verified instructional time by the course sponsor, a certificate of completion or similar documentation signed by the program official; and,
  2. A program description including sponsor, course title, date(s), program objectives/learning outcomes, and content description.
- f. Continuing education should be documented on the appropriate board form, available on the Board website.

### **Georgia State Occupational Therapy Licensing Act Title 43, Chapter 28**

The following is an edited and abridged version of the Act. To read the Act in its entirety, please go to:  
[http://sos.ga.gov/plb/acrobat/Laws/14\\_Occupational\\_Therapists\\_43-28.pdf](http://sos.ga.gov/plb/acrobat/Laws/14_Occupational_Therapists_43-28.pdf)

#### **Subsection 43-28-3 Definitions**

- (5) "Occupational therapy" includes but is not limited to the following:
  - (A) Evaluation and treatment of individuals whose abilities to cope with the tasks of living are threatened or impaired by developmental deficiencies, the aging process, learning disabilities, poverty and cultural differences, physical injury or disease, psychological and social disabilities, or anticipated dysfunction. The treatment utilizes task oriented activities to prevent or correct physical, cognitive, or emotional deficiencies or to minimize the disabling effect of these deficiencies in the life of the individual;
  - (B) Such evaluation techniques as assessment of sensory motor abilities, assessment of the development of self-care activities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance, and appraisal of living areas for persons with disabilities; and
  - (C) Specific occupational therapy techniques, such as activity analysis, activities of daily living skills, the fabrication and application of splints and adaptive devices, sensory motor activities, the use of specifically designed manual and creative activities, guidance in the selection and use of adaptive equipment, specific exercises and physical agent modalities to enhance physical functional performance, work capacities, and treatment techniques for physical capabilities and cognitive retraining. Such techniques are applied in the treatment of individual patients or clients, in groups, or through social systems.
- (6) "Occupational therapy aide" means a person who assists the occupational therapist and the occupational therapy assistant in the practice of occupational therapy and who works under the direct supervision of the occupational therapist.
- (7) "Occupational therapy assistant" means a person licensed to assist the

occupational therapist in the practice of occupational therapy under the supervision of or with the consultation of the licensed occupational therapist and whose license is in good standing.

(8) "Person" means a natural person only, not a legal entity.

(9) "Physical agent modalities" means treatment techniques which utilize heat, light, sound, cold, electricity, or mechanical devices and also means electrical therapeutic modalities which induce heat or electrical current beneath the skin, including but not limited to therapeutic ultrasound, galvanism, microwave, diathermy, and electro muscular stimulation, and also means hydrotherapy.

**Subsection 43-28-8.1. License requirements for therapy techniques involving physical agent modalities**

(a) No person shall utilize occupational therapy techniques involving physical agent modalities unless such person:

- (1) Is licensed according to this chapter; and
- (2) Has utilized such modalities before July 1, 1991, furnishes to the board prior to July 1, 1992, sufficient proof of such prior use, and demonstrates to the board competence in the use of such modalities determined by the board to have been so used prior to July 1, 1991; or
- (3) Has successfully completed a minimum of 90 hours of instruction or training approved by the board which covers the following subjects:
  - (A) Principles of physics related to specific properties of light, water, temperature, sound, or electricity, as indicated by selected modality;
  - (B) Physiological, neurophysiological, and electrophysiological, as indicated, changes which occur as a result of the application of the selected modality;
  - (C) The response of normal and abnormal tissue to the application of the modality;
  - (D) Indications and contraindications related to the selection and application of the modality;
  - (E) Guidelines for treatment or administration of the modality within the philosophical framework of occupational therapy;
  - (F) Guidelines for educating the patient including instructing the patient as to the process and possible outcomes of treatment, including risks and benefits;
  - (G) Safety rules and precautions related to the selected modality;
  - (H) Methods for documenting the effectiveness of immediate and long-term effects of treatment; and
  - (I) Characteristics of the equipment including safe operation, adjustment, and care of the equipment.

**Subsection 43-28-16. Penalty**

(a) Any person who violates this chapter shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not less than \$250.00 and not more than \$1,000.00, or imprisonment for a period not exceeding six months, or both. A license held by any person convicted under this Code

section shall be forfeited and revoked immediately for one year from the date of such conviction.

- (b) It is unlawful for any person who is not registered under this chapter as an occupational therapist or as an occupational therapy assistant or whose registration has been suspended or revoked to use, in connection with his name or place of business, the words "occupational therapist," "licensed occupational therapist," "occupational therapist registered," "occupational therapy assistant," "licensed occupational therapy assistant," "certified occupational therapy assistant"; or the letters "O.T.," "L.O.T.," "O.T.R.," "O.T.A.," "L.O.T.A.," or "C.O.T.A."; or any other words, letters, abbreviations, or insignia indicating or implying that he is an occupational therapist or an occupational therapy assistant or to show in any way, orally, in writing, in print, or by sign, directly or by implication, or to represent himself as an occupational therapist or an occupational therapy assistant.

## **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 like 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**

#### [Rethinking Autonomy and Consent in Healthcare Ethics](#)

Milligan, E., & Jones, J. (2016). Rethinking Autonomy and Consent in Healthcare Ethics. In *Bioethics-Medical, Ethical and Legal Perspectives*. InTech. CC BY 3.0

#### [Ethical Resources for the Clinician: Principles, Values and Other Theories.](#)

Donaldson, T. M. (2012). INTECH Open Access Publisher. CC BY 3.0

#### [Becoming Partners, Retaining Autonomy: Ethical Considerations on the Development of Precision Medicine.](#)

Blasimme, A., & Vayena, E. (2016). Becoming partners, retaining autonomy: ethical considerations on the development of precision medicine. *BMC Medical Ethics*, 17(1), 67. CC BY 4.0

#### [The Importance of Values in Evidence-Based Medicine](#)

Kelly, M. P., Heath, I., Howick, J., & Greenhalgh, T. (2015). The importance of values in evidence-based medicine. *BMC medical ethics*, 16(1), 69. CC BY 4.0

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- Georgia State Board of Occupational Therapy Rules. Chapter 671. Accessed on 2/10/2016 at: <http://rules.sos.ga.gov/gac/671>
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## Ethics – Georgia 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. 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
  
4. 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
  
5. 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

6. 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
7. As per the Georgia OT Rules, which of the following statements regarding supervision is TRUE? (p. 14)
- A. COTAs must be supervised by an OT.
  - B. Supervision requires weekly verbal contact and consultation.
  - C. Supervision requires monthly review of patient care documentation.
  - D. All of the above are true.
8. GA occupational therapy licensees must complete \_\_\_ continuing education hours each biennial licensure period. A maximum of \_\_\_ hours may be obtained by electronic or web-based courses. (p. 15)
- A. 12; 4
  - B. 14; 6
  - C. 24; 12
  - D. 24; 14
9. Occupational therapy aides may treat patients with which one of the following physical agent modalities? (p. 18)
- A. Ultrasound
  - B. Electro muscular stimulation
  - C. Diathermy
  - D. None of the above
10. Which of the following is unethical? (p. 22-23)
- 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. Meeting with a case manager for lunch to inform her about the new therapy services you have available.
  - D. Subleasing office space to an attorney.

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