# Ethics – New York Occupational Therapy

## Goals & Objectives

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

**Course Rationale**
This course was developed to educate, promote and facilitate ethical and legal behavior by New York 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 New York 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 – New York Occupational Therapy

## Course Outline

## 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.

## Rules of the New York Board of Regents
## Part 29, Unprofessional Conduct

The following is an abridged version of the Rules (Part 29). To read the Part 29 of the Rules in their entirety, please go to: http://www.op.nysed.gov/title8/part29.htm

### § 29.1 General provisions.

a. Unprofessional conduct shall be the conduct prohibited by this section.
b. Unprofessional conduct in the practice of any profession licensed, shall include:
   1. willful or grossly negligent failure to comply with substantial provisions of Federal, State or local laws, rules or regulations governing the practice of the profession;
   2. exercising undue influence on the patient or client, including the promotion of the sale of services, goods, appliances or drugs in such manner as to exploit the patient or client for the financial gain of the practitioner or of a third party;
   3. directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services;
   4. permitting any person to share in the fees for professional services, other than: a partner, employee, associate in a professional firm or corporation, professional subcontractor or consultant authorized to practice the same profession, or a legally authorized trainee practicing under the supervision of a licensed practitioner. This prohibition shall include any arrangement or agreement whereby the amount received in payment for furnishing space, facilities, equipment or personnel services used by a professional licensee constitutes a percentage of, or is otherwise dependent upon, the income or receipts of the licensee from such practice;
   5. conduct in the practice of a profession which evidences moral unfitness to practice the profession;
   6. willfully making or filing a false report, or failing to file a report required by law or by the Education Department, or willfully impeding or obstructing such filing, or inducing another person to do so;
   7. failing to make available to a patient or client, upon request, copies of documents in the possession or under the control of the licensee which have been prepared for and paid for by the patient or client;
   8. revealing of personally identifiable facts, data or information obtained in a professional capacity without the prior consent of the patient or client, except as authorized or required by law;
   9. practicing or offering to practice beyond the scope permitted by law, or accepting and performing professional responsibilities which the licensee knows or has reason to know that he or she is not competent to perform, or performing without adequate supervision professional services which the licensee is authorized to perform only under the supervision of a licensed

professional, except in an emergency situation where a person's life or health is in danger;

10. delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience or by licensure, to perform them;
11. performing professional services which have not been duly authorized by the patient or client or his or her legal representative;
12. advertising or soliciting for patronage that is not in the public interest:
    i. Advertising or soliciting not in the public interest shall include, but not be limited to, advertising or soliciting that:
        a. is false, fraudulent, deceptive or misleading;
        b. guarantees any service;
        c. makes any claim relating to professional services or products or the cost or price therefore which cannot be substantiated by the licensee, who shall have the burden of proof;
        d. makes claims of professional superiority which cannot be substantiated by the licensee, who shall have the burden of proof; or
        e. offers bonuses or inducements in any form other than a discount or reduction in an established fee or price for a professional service or product.
    ii. The following shall be deemed appropriate means of informing the public of the availability of professional services:
        a. informational advertising not contrary to the foregoing prohibitions; and
        b. the advertising in a newspaper, periodical or professional directory or on radio or television of fixed prices, or a stated range of prices, for specified routine professional services, provided that if there is an additional charge for related services which are an integral part of the overall service being provided by the licensee, the advertisement shall so state, and provided further that the advertisement indicates the period of time for which the advertised prices shall be in effect.
    iii.
        a. all licensees placing advertisements shall maintain, or cause to be maintained, an exact copy of each advertisement, transcript, tape or videotape thereof as appropriate for the medium used, for a period of one year after its last appearance. This copy shall be made available for inspection upon demand of the Education Department;
        b. a licensee shall not compensate or give anything of value to representatives of the press, radio, television or other communications media in anticipation of or in return for professional publicity in a news item;
    iv. Testimonials, demonstrations, dramatizations, or other portrayals of professional practice are permissible provided that they otherwise

comply with the rules of professional conduct and further provided that the following conditions are satisfied:

a. the patient or client expressly authorizes the portrayal in writing;
b. appropriate disclosure is included to prevent any misleading information or imagery as to the identity of the patient or client;
c. reasonable disclaimers are included as to any statements made or results achieved in a particular matter;
d. the use of fictional situations or characters may be used if no testimonials are included; and
e. fictional client testimonials are not permitted;

13. failing to respond within 30 days to written communications from the Education Department or the Department of Health and to make available any relevant records with respect to an inquiry or complaint about the licensee's unprofessional conduct. The period of 30 days shall commence on the date when such communication was delivered personally to the licensee. If the communication is sent from either department by registered or certified mail, with return receipt requested, to the address appearing in the last registration, the period of 30 days shall commence on the date of delivery to the licensee, as indicated by the return receipt;
14. violating any term of probation or condition or limitation imposed on the licensee by the Board of Regents pursuant to Education Law, Section 6511.

**§ 29.2 General provisions for health professions.**

a. Unprofessional conduct shall also include, in the professions of: occupational therapy and occupational therapy assistant:

1. abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, or abandoning a professional employment by a group practice, hospital, clinic or other health care facility, without reasonable notice and under circumstances which seriously impair the delivery of professional care to patients or clients;
2. willfully harassing, abusing or intimidating a patient either physically or verbally;
3. failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Unless otherwise provided by law, all patient records must be retained for at least six years. Records of minor patients must be retained for at least six years, and until one year after the minor patient reaches the age of 21 years;
4. using the word "Doctor" in offering to perform professional services without also indicating the profession in which the licensee holds a doctorate;
5. failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of the licensed professional;
6. guaranteeing that satisfaction or a cure will result from the performance of professional services;
7. ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient;

8. claiming or using any secret or special method of treatment which the licensee refuses to divulge to the State Board for the profession;
9. failing to wear an identifying badge, which shall be conspicuously displayed and legible, indicating the practitioner's name and professional title authorized pursuant to the Education Law, while practicing as an employee or operator of a hospital, clinic, group practice or multi-professional facility, registered pharmacy, or at a commercial establishment offering health services to the public;
10. entering into an arrangement or agreement with a pharmacy for the compounding and/or dispensing of coded or specially marked prescriptions;
11. with respect to all professional practices conducted under an assumed name, other than facilities licensed pursuant to article 28 of the Public Health Law or article 13 of the Mental Hygiene Law, failing to post conspicuously at the site of such practice the names and the licensure field of all of the principal professional licensees engaged in practice at that site (i.e., principal partners, officers or principal shareholders);
12. issuing prescriptions for drugs and devices which do not contain the following information: the date written, the prescriber's name, address, telephone number, profession and registration number, the patient's name, address and age, the name, strength and quantity of the prescribed drug or device, as well as the directions for use by the patient. In addition, all prescriptions for controlled substances shall meet the requirements of article 33 of the Public Health Law;
13. failing to use scientifically accepted infection prevention techniques appropriate to each profession for the cleaning and sterilization or disinfection of instruments, devices, materials and work surfaces, utilization of protective garb, use of covers for contamination-prone equipment and the handling of sharp instruments. Such techniques shall include but not be limited to:
    i. wearing of appropriate protective gloves at all times when touching blood, saliva, other body fluids or secretions, mucous membranes, non-intact skin, blood-soiled items or bodily fluid-soiled items, contaminated surfaces, and sterile body areas, and during instrument cleaning and decontamination procedures;
    ii. discarding gloves used following treatment of a patient and changing to new gloves if torn or damaged during treatment of a patient; washing hands and donning new gloves prior to performing services for another patient; and washing hands and other skin surfaces immediately if contaminated with blood or other body fluids;
    iii. wearing of appropriate masks, gowns or aprons, and protective eyewear or chin-length plastic face shields whenever splashing or spattering of blood or other body fluids is likely to occur;
    iv. sterilizing equipment and devices that enter the patient's vascular system or other normally sterile areas of the body;

v. sterilizing equipment and devices that touch intact mucous membranes but do not penetrate the patient's body or using high-level disinfection for equipment and devices which cannot be sterilized prior to use for a patient;
vi. using appropriate agents, including but not limited to detergents for cleaning all equipment and devices prior a sterilization or disinfection;
vii. cleaning, by the use of appropriate agents, including but not limited to detergents, equipment and devices which do not touch the patient or that only touch the intact skin of the patient;
viii. maintaining equipment and devices used for sterilization according to the manufacturer's instructions;
ix. adequately monitoring the performance of all personnel, licensed or unlicensed, for whom the licensee is responsible regarding infection control techniques;
x. placing disposable used syringes, needles, scalpel blades, and other sharp instruments in appropriate puncture-resistant containers for disposal; and placing reusable needles, scalpel blades, and other sharp instruments in appropriate puncture-resistant containers until appropriately cleaned and sterilized;
xi. maintaining appropriate ventilation devices to minimize the need for emergency mouth-to-mouth resuscitation;
xii. refraining from all direct patient care and handling of patient care equipment when the health care professional has exudative lesions or weeping dermatitis and the condition has not been medically evaluated and determined to be safe or capable of being safely protected against in providing direct patient care or in handling patient care equipment; and
xiii. placing all specimens of blood and body fluids in well-constructed containers with secure lids to prevent leaking; and cleaning any spill of blood or other body fluid with an appropriate detergent and appropriate chemical germicide;

## New York Commissioner's Regulations, Part 76 – Occupational Therapy

**The following is an abridged version of the Regulations, to view the Regulations in their entirety, please go to: http://www.op.nysed.gov/prof/ot/part76.htm**

### §76.8 Supervision of occupational therapy assistant.

a. A written supervision plan, acceptable to the occupational therapist or licensed physician providing direction and supervision, shall be required for each occupational therapy assistant providing services pursuant to section 7906(7) of the Education Law. The written supervision plan shall specify the names, professions and other credentials of the persons participating in the supervisory process, the frequency of formal supervisory contacts, the methods (e.g. in-person, by telephone) and types (e.g. review of charts, discussion with occupational therapy assistant) of supervision, the content

areas to be addressed, how written treatment notes and reports will be reviewed, including, but not limited to, whether such notes and reports will be initialed or co-signed by the supervisor, and how professional development will be fostered.

b. Documentation of supervision shall include the date and content of each formal supervisory contact as identified in the written supervision plan and evidence of the review of all treatment notes, reports and assessments.
c. Consistent with the requirements of this section, the determination of the level and type of supervision shall be based on the ability level and experience of the occupational therapy assistant providing the delegated occupational therapy services, the complexity of client needs, the setting in which the occupational therapy assistant is providing the services, and consultation with the occupational therapy assistant.
d. The supervision plan shall require that the occupational therapist or licensed physician be notified whenever there is a clinically significant change in the condition or performance of the client, so that an appropriate supervisory action can take place.
e. Direction and supervision means that the occupational therapist or licensed physician:
    1. initiates, directs and participates in the initial evaluation, interprets the evaluation data, and develops the occupational therapy services plan with input from the occupational therapy assistant;
    2. participates, on a regular basis, in the delivery of occupational therapy services;
    3. is responsible for determining the need for continuing, modifying, or discontinuing occupational therapy services, after considering any reports by the occupational therapy assistant of any changes in the condition of the client that would require a change in the treatment plan;
    4. takes into consideration information provided about the client's responses to and communications during occupational therapy services; and
    5. is available for consultation with the occupational therapy assistant in a timely manner, taking into consideration the practice setting, the condition of the client and the occupational therapy services being provided.
f. In no event shall the occupational therapist or licensed physician supervise more than five occupational therapy assistants, or its full time equivalent, provided that the total number of occupational therapy assistants being supervised by a single occupational therapist or licensed physician shall not exceed ten.

## New York Occupational Therapy Practice Guidelines

**The following is an abridged version of the Guidelines, to view the Guidelines in the entirety, please go to: http://www.op.nysed.gov/prof/ot/otguidelines.htm**

### Referrals

Occupational therapists can perform occupational therapy evaluations without a referral or prescription. However, to implement an OT treatment plan, under certain circumstances described below, you must have a referral or prescription from a licensed health care provider.

Effective February 3, 2012, Education Law 7901 was amended to provide that an occupational therapy treatment program "designed to restore function" shall be rendered on the prescription or referral of a physician, nurse practitioner or other health care provider acting within his or her scope. Prior to this amendment, an occupational therapy treatment program could only be provided following receipt of a prescription or referral, and that prescription or referral could only be provided by a physician or nurse practitioner. The board has interpreted this change to mean that an OT treatment program that is not restoring a function can be provided without a script, and believes that this would apply typically to school age children receiving therapy to develop functions they never had (e.g. handwriting). Medicaid, an insurance program, or school district may still have a policy that would require a prescription or referral in all instances. When required, prescriptions and referrals establish an important link between the patient's/client's occupational therapist and his/her primary healthcare provider. The referral/prescription becomes part of the record which the occupational therapist must maintain for each patient/client you serve.

### Physical Agent Modalities

Although not defined in Education Law, physical agent modalities are generally understood to be those modalities that produce a response in soft tissue through the use of light, water, temperature, sound, or electricity. Physical agent modalities may include, but are not limited to, paraffin baths, hot packs, cold packs, fluidotherapy, contrast baths, ultrasound, whirlpool and electrical stimulation units (e.g., functional electrical stimulation (FES)/neuromuscular electrical stimulation (NMES) devices, transcutaneous electrical nerve stimulator) and others.

Commissioner's Regulations allow occupational therapy professionals to use modalities and techniques based on approaches taught in occupational therapy curricula and included in professional education programs in occupational therapy registered by the department. Professional educational programs in New York State provide an instructional foundation for the use of physical agent modalities, including deep heat modalities.

Occupational therapy professionals may use physical agent modalities only as part of a program of occupational therapy. Physical agent modalities may not be used as a stand-alone treatment because alone, physical agent modalities do not align with service standards described in the scope of practice of occupational therapy, i.e. "a program of purposeful activities to develop or maintain adaptive skills...."

Prior to using PAMs independently, occupational therapy professionals must complete appropriate education, training and supervision to become competent to provide these services.

**Scope of Practice and Scope of Competence**

Education Law defines the scope of practice of occupational therapy as:

*The functional evaluation of the client and the planning and utilization of a program of purposeful activities to develop or maintain adaptive skills, designed to achieve maximal physical and mental functioning of the patient in his daily life tasks.*

Your scope of practice sets the outside parameters of your practice. Your scope of competence is comprised of those aspects of occupational therapy in which you are competent.

Competence is based on the application of knowledge, performance skills, interpersonal abilities, critical reasoning skills and ethical reasoning skills, as demonstrated in the performance of one's professional role(s).
It is your responsibility to limit your practice to areas in which you have been trained and educated, and with which you are familiar and competent.
A professional's scope of competence changes over time. You may, in fact, lose some areas of competence as you acquire others. It is your professional and ethical responsibility to know and respect your limits. Ongoing training and education will allow you to expand the depth and breadth of your practice, within the statutory confines of the definition of your profession. The reference to "occupation" in "occupational therapy" is taken in the context of a person's use of time, energy, interest and attention. This encompasses a wide range of learning and performance activities.

**Credentials**

All consumers of services offered by professionals licensed by the New York State Education Department have the legal right to verify the credentials of those professionals and know the names and titles of licensed professionals who provide services.

By law, the use of the title "occupational therapist" is limited to a person licensed to practice occupational therapy.

An occupational therapist who holds National Board for the Certification of Occupational Therapy (NBCOT) certification typically uses the designator "OTR/L."

An occupational therapy assistant who holds NBCOT certification typically uses the designation "COTA."

A student providing occupational therapy services should identify himself/herself as "OT student."

A licensed occupational therapist who does not hold NBCOT certification may identify himself/herself as "OT/L."

A NYS registered occupational therapy assistant who does not hold NBCOT certification may identify himself/herself as "OTA."

There is no provision for occupational therapy aides in New York State. Aides should **not** be called "OT aides," nor should they be delegated any professional responsibilities. Use of the title "OT aide" could mislead the public into believing that such aides are authorized to provide professional services.

## Ethics 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

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

## References


American Occupational Therapy Association. (2015). Occupational therapy code of ethics. American Journal of Occupational Therapy, 69(Suppl. 3).

Atanelov, L., Stiens, S. A., & Young, M. A. (2015). History of Physical Medicine and Rehabilitation and Its Ethical Dimensions. *AMA journal of ethics*, *17*(6), 568.

Bushby, K., Chan, J., Druif, S., Ho, K., & Kinsella, E. A. (2015). Ethical tensions in occupational therapy practice: A scoping review. *British Journal of Occupational Therapy*, *78*(4), 212-221.

Corey, G., Corey, M., Corey, C., & Callanan, P. (2014). *Issues and Ethics in the Helping Professions with 2014 ACA Codes*. Cengage Learning.

Dige, M. (2009). Occupational therapy, professional development, and ethics.*Scandinavian Journal of Occupational Therapy*, *16*(2), 88-98.

Drolet, M. J., & Hudon, A. (2015). Theoretical frameworks used to discuss ethical issues in private physiotherapy practice and proposal of a new ethical tool. *Medicine, Health Care and Philosophy*, *18*(1), 51-62.

Foye, S. J., Kirschner, K. L., Wagner, L. C. B., Stocking, C., & Siegler, M. (2015). Ethical issues in rehabilitation: A qualitative analysis of dilemmas identified by occupational therapists.

Hordichuk, C. J., Robinson, A. J., & Sullivan, T. M. (2015). Conceptualising professionalism in occupational therapy through a Western lens. *Australian Occupational Therapy Journal*.

Hudon, A., Laliberté, M., Hunt, M., Sonier, V., Williams-Jones, B., Mazer, B., & Ehrmann Feldman, D. (2014). What place for ethics? An overview of ethics teaching in occupational therapy and physiotherapy programs in Canada. *Disability and rehabilitation*, *36*(9), 775-780.

Hunt, M. R., Schwartz, L., Sinding, C., & Elit, L. (2014). The ethics of engaged presence: a framework for health professionals in humanitarian assistance and development work. *Developing world bioethics*, *14*(1), 47-55.

Kulju, K., Stolt, M., Suhonen, R., & Leino-Kilpi, H. (2015). Ethical competence a concept analysis. *Nursing ethics*, 0969733014567025.

Levack, W. M. (2009). Ethics in goal planning for rehabilitation: a utilitarian perspective. *Clinical rehabilitation*.

New York State Education Department Occupational Therapy Guidelines (2010)

New York State Education Department, Rules of the Board of Regents, Part 29, Unprofessional Conduct (October, 5, 2011)

New York State Education Department, Commissioner's Regulations, Part 76, Occupational Therapy (April, 28, 2015)

Silén, M., Ramklint, M., Hansson, M. G., & Haglund, K. (2014). Ethics rounds an appreciated form of ethics support. *Nursing ethics*, 0969733014560930.

Slater, D. Y. (2014). Consensus Statements on Occupational Therapy Ethics Related to Driving. *Occupational therapy in health care*, *28*(2), 163-168.

van der Dam, S., Molewijk, B., Widdershoven, G. A., & Abma, T. A. (2014). Ethics support in institutional elderly care: a review of the literature. *Journal of medical ethics*, *40*(9), 625-631.

## Ethics – New York 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. The Rules of the New York Board of Regents, Subsection 29.2 requires NY OT professionals to maintain patient records for at least _____ years. (p. 15)
   A. 4
   B. 5
   C. 6
   D. 7

9. New York OT Practice Guidelines allow OT Aides to perform which of the following professional responsibilities: (p. 21)
   A. Monitoring of exercise
   B. Documentation of therapeutic activities
   C. Application of thermal modalities
   D. None of the above (The title of OT aide is not permitted in New York State)

10. Which of the following is unethical? (p. 25)
    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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