Ethics & Jurisprudence - Utah Occupational Therapy

Goals & Objectives

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

Course Rationale
This course was developed to meet the Ethics & Jurisprudence requirements of Utah Administrative Code R156-42a-304(4)(e); and is intended to educate, promote and facilitate ethical and legal behavior of Utah 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 Utah 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.

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Course Outline

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Ethics Overview

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

Why Ethics are Important

Ethics are important on several levels.

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

Ethics vs. Morals

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

Ethical Questions

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

Ethics Theories

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

Utilitarianism

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

Social Contract Theory

Social contract theories believe that the moral code is created by the people who form societies. These people come together to create society for the purpose of protection and gaining other benefits of social cooperation. These persons agree to regulate and restrict their conduct to achieve this end.

Deontological or Duty Theory

Under this theory you determine if an act or rule is morally right or wrong if it meets a moral standard. The morally important thing is not consequences but the way choosers think while they make choices.

Ethical Intuitionism

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

Ethical Egoism

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

Natural Law Theory

This is a moral theory which claims that just as there are physical laws of nature, there are moral laws of nature that are discoverable. This nature determines what is good or bad for that thing. In the case of human beings, the moral laws of nature stem from our unique capacity for reason. When we act against our own reason, we are violating our nature, and therefore acting immorally.

Virtue Ethics

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

- **Autonomy:** the duty to maximize the individual's right to make his or her own decisions.
- **Beneficence:** the duty to do good.
- **Confidentiality:** the duty to respect privacy of information.
- **Finality:** the duty to take action that may override the demands of law, religion, and social customs.
- **Justice:** the duty to treat all fairly, distributing the risks and benefits equally.
- **Nonmaleficence:** the duty to cause no harm.
- **Understanding/Tolerance:** the duty to understand and to accept other viewpoints if reason dictates.
- **Respect for persons:** the duty to honor others, their rights, and their responsibilities.
- **Universality:** the duty to take actions that hold for everyone, regardless of time, place, or people involved.
- **Veracity:** the duty to tell the truth.

How to Make Right Decisions

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

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

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

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

Are my actions ethical?
Professional ethical behavior as it is defined in this context relates to actions that are consistent with the normative standards established or practiced by others in the same profession. For occupational therapists and occupational therapist assistants, acceptable ethical practice is documented in the AOTA's Code of Ethics. All OTs and OTAs, even those who are not members of the AOTA, are expected to follow the AOTA guidelines because its Code of Ethics has been established as the accepted and de facto standard of practice throughout the profession.

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

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

AOTA Code of Ethics

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

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

Informed Consent

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

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

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

Refusing Treatment

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

Practitioners should take care not to assume that a patient who refuses recommended treatment lacks decision-making capacity. A capacity assessment is appropriate if the practitioner has reason to believe the patient might lack one or more of the components of decision-making capacity. When decision-making capacity is not in question, practitioners must respect the patient's decision to decline an intervention, even if they believe the decision is not the best one that could have been made. However, this does not mean that health care professionals should never question the patient's decision, or never try to persuade the patient to accept treatment. For example, by exploring the reasons for refusal with the patient, a practitioner might learn that the patient simply needs more information before deciding to proceed.

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

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

Relationships

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

Professionalism

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

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

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

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

Boundaries

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

Legal Aspects

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

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

Other Problematic Relationships

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

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

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

Gifts and Conflict of Interest

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

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

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

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

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

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

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

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

coordinated efforts on the part of clinical and administrative leaders, as well as development and careful implementation of clear, well-considered policy.

Confidentiality

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

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

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

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

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

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

Utah Administrative Code
Rule R156-42a. Occupational Therapy Practice Act Rule

The following is an edited and abridged version of the Utah OT Practice Act. To read the regulations in their entirety, please go to: http://www.rules.utah.gov/publicat/code/r156/r156-42a.htm#T8

R156-42a-101. Title.
This rule is known as the "Occupational Therapy Practice Act Rule".

R156-42a-102. Definitions.
In addition to the definitions in Title 58, Chapters 1 and 42a, as used in Title 58, Chapters 1 and 42a, or this rule:
(1) "Manual therapy", as used in Subsection 58-42a-102(6)(b)(vii)(L), means the use of skilled hand movements to manipulate tissues of the body for a therapeutic purpose.
(2) "Physical agent modalities", as used in Subsection 58-42a-102(6)(b)(vii)(L), means specialized treatment procedures including: superficial thermal agents, deep thermal agents, electrotherapeutic agents, and mechanical devices.
(3) "Qualified continuing professional education", as used in Subsection 58-42a-303.5(1), means continuing education that meets the standards set forth in Subsection R156-42a-304.
(4) "Unprofessional conduct" as defined in Title 58, Chapters 1 and 42a, is further defined, in accordance with Subsection 58-1-203(1)(e), in Section R156-42a-502.
(5) "Wound care", as used in Subsection 58-42a-102(6)(b)(vii)(L), means:
(a) prevention of interruptions in skin and tissue integrity; and
(b) care and management of interruptions in skin and tissue integrity.

R156-42a-302b. Qualifications for Licensure - Education Requirements.
The education requirements for licensure, in accordance with Section 58-42a-302, are established as follows:
(1) An applicant for licensure as an occupational therapist shall graduate from an occupational therapy program accredited by the American Occupational Therapy Association's Accreditation Council for Occupational Therapy Education.
(2) An applicant for licensure as an occupational therapy assistant shall graduate from an occupational therapy assistant program accredited by the American Occupational Therapy Association's Accreditation Council for Occupational Therapy Education.

R156-42a-302d. Qualifications for Licensure - Examination Requirements.
The examination requirements for licensure, in accordance with Section 58-42a-302, are established as follows:
(1) An applicant for licensure as an occupational therapist shall pass the examination for certification from the National Board for Certification in Occupational Therapy as an occupational therapist registered.
(2) An applicant for licensure as an occupational therapy assistant shall hold current certification from the National Board for Certification in Occupational Therapy as a certified occupational therapy assistant.

R156-42a-303. Renewal Cycle - Procedures.
(1) In accordance with Subsection 58-1-308(1), the renewal date for the two-year renewal cycle applicable to licenses under Title 58, Chapter 42a is established by rule in R156-1-308a.
(2) Renewal procedures shall be in accordance with Section R156-1-308c.

R156-42a-304. Continuing Education.
(1) Continuing education required by Subsection 58-42a-302.5(1) shall consist of 24 hours of qualified continuing professional education in each preceding two-year period of licensure or prior to reinstatement of licensure. Each hour of continuing professional education may include a 10-minute break.
(2) If a renewal period is shortened or extended to affect a change of renewal cycle, the continuing professional education hours required for that renewal period shall be increased or decreased accordingly as a pro rata amount of the requirements of a two-year period.
(3) The required number of contact hours of continuing professional education for an individual who first becomes licensed during the two-year renewal cycle shall be decreased by a pro-rata amount.
(4) The standards for qualified continuing professional education include:
(a) an identifiable clear statement of purposed and defined objective for the educational program directly related to the practice of occupational therapy;
(b) relevance to the licensee's professional practice;
(c) presentation in a competent, well organized, and sequential manner consistent with the stated purpose and objective of the continuing education;
(d) preparation and presentation by individuals who are qualified by education, training, and experience;
(e) completion of a minimum of two hours related to legal and ethical principles of practice; and
(f) verification from the continuing education provider to licensee of the completed continuing education.
(5) Records of qualified continuing education completion shall be maintained by the licensee and reported to the Division when requested.

R156-42a-502. Unprofessional Conduct.
"Unprofessional conduct" includes:
(1) delegating supervision, or occupational therapy services, care or responsibilities not authorized under Title 58, Chapter 42a or this rule;
(2) engaging in or attempting to engage in the use of physical agent modalities, wound care, or manual therapy when not competent to do so by education, training, or experience;
(3) failing to provide general supervision as set forth in Title 58, Chapter 42a and this rule;
(4) failing to cosign COTA discharge documentation within 30 days pursuant to R156-42a-601; and

(5) violating any provision of the American Occupational Therapy Association Code of Ethics, last amended 2015, which is hereby adopted and incorporated by reference.

R156-42a-601. Practice Standards.
(1) A certified occupational therapist assistant (COTA), after consultation with the supervising occupational therapist (OT), may discharge an individual from on-going service only if there is no evaluation component associated with the discharge from service. The supervising OT shall co-sign the appropriate documentation within 30 days.
(2) An occupational therapist shall complete formal specialized wound care training or certification, including didactic and clinical components, if engaging in the care and management of interruptions in skin and tissue integrity.
(3) Occupational therapy treatment shall be performed by an occupational therapist or certified occupational therapist assistant who is able to demonstrate and document evidence of theoretical background, technical skill, and competence in the therapies performed.

Utah Code Title 58, Chapter 42a - Occupational Therapy Practice Act

The following is an edited and abridged version of the Utah Occupational Therapy Practice A.
To read the Act in its entirety, please go to: http://le.utah.gov/xcode/Title58/Chapter42a/58-42a.html

Part 1: General Provisions

58-42a-102 Definitions.
In addition to the definitions in Section 58-1-102, as used in this chapter:
(1) “Board” means the Board of Occupational Therapy
(2)
(a) “Individual treatment plan” means a written record composed for each client by a person licensed under this chapter to engage in the practice of occupational therapy.
(b) “Individual treatment plan” includes:
(i) planning and directing specific exercises and programs to improve sensory integration and motor functioning at the level of performance neurologically appropriate for the individual’s stage of development;
(ii) establishing a program of instruction to teach a client skills, behaviors, and attitudes necessary for the client’s independent productive, emotional, and social functioning;
(iii) analyzing, selecting, and adapting functional exercises to achieve and maintain the client’s optimal functioning in activities of daily living and to prevent further disability; and
(iv) planning and directing specific programs to evaluate and enhance perceptual, motor, and cognitive skills.
(3) “Occupational therapist” means a person licensed under this chapter to practice occupational therapy.
(4) “Occupational therapy aide” means a person who is not licensed under this chapter but who provides supportive services under the supervision of an occupational therapist or occupational therapy assistant.
(5) “Occupational therapy assistant” means a person licensed under this chapter to practice occupational therapy under the supervision of an occupational therapist as described in Sections 58-42a-305 and 58-42a-306.
(6)
(a) “Practice of occupational therapy” means the therapeutic use of everyday life activities with

an individual:
(i) that has or is at risk of developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction; and
(ii) to develop or restore the individual's ability to engage in everyday life activities by addressing physical, cognitive, psychosocial, sensory, or other aspects of the individual's performance.
(b) "Practice of occupational therapy" includes:
(i) establishing, remediating, or restoring an undeveloped or impaired skill or ability of an individual;
(ii) modifying or adapting an activity or environment to enhance an individual's performance;
(iii) maintaining and improving an individual's capabilities to avoid declining performance in everyday life activities;
(iv) promoting health and wellness to develop or improve an individual's performance in everyday life activities;
(v) performance-barrier prevention for an individual, including disability prevention;
(vi) evaluating factors that affect an individual's activities of daily living in educational, work, play, leisure, and social situations, including:
(A) body functions and structures;
(B) habits, routines, roles, and behavioral patterns;
(C) cultural, physical, environmental, social, virtual, and spiritual contexts and activity demands that affect performance; and
(D) motor, process, communication, interaction, and other performance skills;
(vii) providing interventions and procedures to promote or enhance an individual's safety and performance in activities of daily living in educational, work, and social situations, including:
(A) the therapeutic use of occupations and exercises;
(B) training in self-care, self-management, home-management, and community and work reintegration;
(C) the development, remediation, or compensation of behavioral skills and physical, cognitive, neuromuscular, and sensory functions;
(D) the education and training of an individual's family members and caregivers;
(E) care coordination, case management, and transition services;
(F) providing consulting services to groups, programs, organizations, or communities,
(G) modifying the environment and adapting processes, including the application of ergonomic principles;
(H) assessing, designing, fabricating, applying, fitting, and providing training in assistive technology, adaptive devices, orthotic devices, and prosthetic devices;
(I) assessing, recommending, and training an individual in techniques to enhance functional mobility, including wheelchair management;
(J) driver rehabilitation and community mobility;
(K) enhancing eating and feeding performance; and
(L) applying physical agent modalities, managing wound care, and using manual therapy techniques to enhance an individual's performance skills, if the occupational therapist has received the necessary training as determined by division rule in collaboration with the board.
(7) "Unlawful conduct" means the same as that term is defined in Sections 58-1-501 and 58-42a-501.
(8) "Unprofessional conduct" means the same as that term is defined in Sections 58-1-501 and 58-42a-502.

Part 2: Board

58-42a-201 Board.
(1) There is created the Board of Occupational Therapy consisting of three licensed occupational therapists, one licensed occupational therapy assistant, and one member of the general public.
(2) The board shall be appointed and serve in accordance with Section 58-1-201.

(3) The duties and responsibilities of the board shall be in accordance with Sections 58-1-202 and 58-1-203.
(4) The board shall designate one of its members on a permanent or rotating basis to:
(a) assist the division in reviewing complaints concerning the unlawful or unprofessional practice of a licensee; and
(b) advise the division in its investigation of these complaints.
(5) A board member who has, under Subsection (4), reviewed a complaint or advised in its investigation may not participate with the board while the board serves as a presiding officer of an administrative proceeding concerning the complaint.

Part 3: Licensing

58-42a-301 Licensure required -- License classification.
(1) A license is required to engage in the practice of occupational therapy, except as specifically provided in Section 58-1-307 or 58-42a-304.
(2) The division shall issue to a person who qualifies under this chapter a license in the classification of:
(a) occupational therapist; or
(b) occupational therapy assistant.
(3) Nothing in this chapter shall permit an individual licensed under this chapter to engage in the practice of mental health therapy.

58-42a-302 Qualifications for licensure.
(1) An applicant for licensure as an occupational therapist shall:
(a) submit an application in a form as prescribed by the division;
(b) pay a fee as determined by the department under Section 63J-1-504;
(c) be of good moral character as it relates to the functions and responsibilities of the practice of occupational therapy;
(d) graduate with a bachelor's or graduate degree for the practice of occupational therapy from an education program accredited by the American Occupational Therapy Association's Accreditation Council for Occupational Therapy Education, a predecessor organization, or an equivalent organization as determined by division rule;
(e) if applying for licensure on or after July 1, 2015, complete a minimum of 24 weeks of supervised fieldwork experience; and
(f) pass an examination approved by the division in consultation with the board and administered by the National Board for Certification in Occupational Therapy, or by another nationally recognized credentialing body as approved by division rule, to demonstrate knowledge of the practice, skills, theory, and professional ethics related to occupational therapy.
(2) All applicants for licensure as an occupational therapy assistant shall:
(a) submit an application in a form as prescribed by the division;
(b) pay a fee as determined by the department under Section 63J-1-504;
(c) be of good moral character as it relates to the functions and responsibilities of the practice of occupational therapy;
(d) graduate from an educational program for the practice of occupational therapy as an occupational therapy assistant that is accredited by the American Occupational Therapy Association's Accreditation Council for Occupational Therapy Education, a predecessor organization, or an equivalent organization as determined by division rule;
(e) if applying for licensure on or after July 1, 2015, complete a minimum of 16 weeks of supervised fieldwork experience; and
(f) pass an examination approved by the division in consultation with the board and administered by the National Board for Certification in Occupational Therapy, or by another nationally recognized credentialing body as approved by division rule, to demonstrate knowledge of the practice, skills, theory, and professional ethics related to occupational therapy.
(3) Notwithstanding the other requirements of this section, the division may issue a license as an

occupational therapist or as an occupational therapy assistant to an applicant who:
(a) meets the requirements of receiving a license by endorsement under Section 58-1-302; or
(b) has been licensed in a state, district, or territory of the United States, or in a foreign country, where the education, experience, or examination requirements are not substantially equal to the requirements of this state, if the applicant passes the applicable examination described in Subsection (1)(f) or (2)(f).

58-42a-303 Term of license -- Expiration -- Renewal.
(1) The division shall issue each license under this chapter in accordance with a two-year renewal cycle established by division rule.
(2) The division may by rule extend or shorten a renewal period by as much as one year to stagger the renewal cycles it administers.
(3) Each license automatically expires on the expiration date shown on the license unless the licensee renews it in accordance with Section 58-1-308.

58-42a-303.5 Continuing education.
(1) As a condition for renewal of a license under this chapter, a licensee shall complete 24 hours of qualified continuing professional education, in accordance with standards defined by division rule in collaboration with the board, during each two-year licensure cycle.
(2) If a renewal cycle is extended or shortened under Subsection (1), the continuing education hours required for license renewal under this section shall be increased or decreased proportionally.

58-42a-304 Exemptions from licensure.
In addition to the exemptions from licensure in Section 58-1-307, the following may engage in the stated limited acts or practices without being licensed under this chapter:
(1) a person licensed in the state who is engaging in the practice of the person's profession or occupation as defined in statute under which the person is licensed;
(2) a person pursuing a course of study leading to a degree for the practice of occupational therapy at an accredited education program, if that person is acting under appropriate supervision and is designated by a title that clearly indicates the person's status as a student; and
(3) a person fulfilling the supervised fieldwork experience requirements for licensure described in Section 58-42a-302, if the person is acting under appropriate supervision and is designated by a title that clearly indicates the person is performing supervised fieldwork experience to qualify for a license under this chapter.

58-42a-305 Limitation upon occupational therapy services provided by an occupational therapy assistant and an occupational therapy aide.
(1) An occupational therapy assistant:
(a) may only perform occupational therapy services under the supervision of an occupational therapist as described in Section 58-42a-306;
(b) may not write an individual treatment plan;
(c) may not approve or cosign modifications to an individual treatment plan; and
(d) may contribute to and maintain an individual treatment plan.
(2) An occupational therapy aide:
(a) may only perform occupational therapy services under the direct supervision of an occupational therapist or an occupational therapy assistant;
(b) may not write, modify, contribute, or maintain an individual treatment plan; and
(c) may only perform tasks that are repetitive and routine for which the aide has been trained and has demonstrated competence.

58-42a-306 Supervision requirements.
An occupational therapist who is supervising an occupational therapy assistant shall:
(1) write or contribute to an individual treatment plan before referring a client to a supervised occupational therapy assistant for treatment;
(2) approve and cosign on all modifications to the individual treatment plan;

(3) meet face to face with the supervised occupational therapy assistant as often as necessary but at least once every two weeks in person or by video conference, and at least one time every month in person, to adequately provide consultation, advice, training, and direction to the occupational therapy assistant;
(4) meet with each client who has been referred to a supervised occupational therapy assistant at least once each month, to further assess the patient, evaluate the treatment, and modify the individual's treatment plan, except that if the interval of client care occurs one time per month or less, the occupational therapist shall meet with the client at least once every four visits;
(5) supervise no more than two full-time occupational therapy assistants at one time, or four part-time occupational therapy assistants if the combined work hours of the assistants do not exceed 40 hours per week, unless otherwise approved by the division in collaboration with the board;
(6) remain responsible for client treatment provided by the occupational therapy assistant; and
(7) fulfill any other supervisory responsibilities as determined by division rule.

Part 4: License Denial and Discipline

58-42a-401 Denial of license -- Discipline.
The division may refuse to issue a license to an applicant, refuse to renew the license of a licensee, revoke, suspend, restrict, or place on probation the license of a licensee, issue a public or private reprimand to a licensee, and issue a cease and desist order under the grounds specified in Section 58-1-401.

Part 5: Unlawful and Unprofessional Conduct

58-42a-501 Unlawful conduct.
"Unlawful conduct," as defined in Section 58-1-501 and as may be further defined by division rule, includes:
(1) engaging or offering to engage in the practice of occupational therapy unless licensed under this chapter or exempted from licensure under Section 58-1-307 or 58-42a-304;
(2) using the title occupational therapist or occupational therapy assistant unless licensed under this chapter;
(3) employing or aiding and abetting an unqualified or unlicensed person to engage or offer to engage in the practice of occupational therapy unless the person is exempted from licensure under Section 58-1-307 or 58-42a-304; and
(4) obtaining a license under this chapter by means of fraud, misrepresentation, or concealment of a material fact.

58-42a-502 Unprofessional conduct.
"Unprofessional conduct," as defined in Section 58-1-501 and as may be further defined by division rule, includes:
(1) being convicted of a crime in any court except for minor offenses;
(2) violating a lawful order, rule, or regulation adopted by the division in consultation with the board;
(3) providing substandard care as an occupational therapist due to a deliberate or negligent act or failure to act regardless of whether actual injury to the client is established;
(4) providing substandard care as an occupational therapy assistant, including exceeding the authority to perform components of intervention selected and delegated by the supervising occupational therapist, regardless of whether actual injury to the client is established;
(5) knowingly delegating responsibilities related to the practice of occupational therapy to an individual, including an occupational therapy aide, who does not have the knowledge, skills, or abilities to perform those responsibilities;
(6) failing to provide appropriate supervision in accordance with this chapter to an occupational therapy assistant or occupational therapy aide;
(7) practicing as an occupational therapist or occupational therapy assistant when physical or mental impairment of the occupational therapist or occupational therapy assistant prevents the provision of competent services to clients;

(8) having had an occupational therapist, occupational therapy assistant, or equivalent license or application refused, revoked, suspended, or other disciplinary action taken in another state, United States territory, or country;
(9) engaging in sexual misconduct, including:
  (a) engaging in or soliciting a sexual relationship with a client;
  (b) making a sexual advance, requesting a sexual favor, or engaging in physical contact of a sexual nature with a client; and
  (c) engaging in verbal or physical conduct of a sexual nature in the presence of a client; and
(10) abandoning or neglecting a client in need of immediate professional care without making reasonable arrangements for the continuation of care.

Ethical Case Studies

Case Study #1 - Confidentiality

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

Is this a breach in confidentiality?

The information contained in each patient's medical record must be safeguarded against disclosure or exposure to nonproprietary individuals. The right to know any medical information about another is always predicated on a sound demonstration of need. Frequently, many individuals require access to information contained in a patient's medical record. Their right to access this information is limited to only that information which is deemed necessary for them perform their job in a safe, effective, and responsible manner.

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

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

Case Study #2 – Informed Consent

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

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

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

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

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

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

The therapist's actions in this case were not sufficient. None of the required information was offered to the patient. The most important thing the therapist failed to explain to the patient was the consequences of non-treatment. The patient cannot make an informed decision regarding therapy without this

information. It could be argued that her decision to refuse therapy may have changed had she known that one of the consequences of this decision could be the development of secondary complications. (I.e. increased risk of morbidity or mortality).

Case Study #3- Medical Necessity

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

Is limiting care in this manner ethical?

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

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

Case Study #4 – Conflicts of Interest

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

Does this represent a conflict of interest?

Yes, there exists a conflict of interest in this situation. Debi has two primary obligations to fulfill. The first is to her patient. It is her professional duty to recommend to her patient a brace that, in her judgment, will benefit them the most. The second obligation is to her employer, the hospital. As an employee of the hospital it is her responsibility to manage expenses by thoroughly and objectively seeking effective products that also demonstrate economic efficiency. The conflict of interest occurs when she begins to accept compensation from the vendor in direct or indirect response for her brace orders. Even if she truly

believes it is the best brace for her patient, and it is the most cost effective brace the hospital could purchase, by accepting the money she has established at least an apparent conflict of interest. Under this situation she is obligated to disclose to all parties her financial interest in ordering the braces. This disclosure is necessitated because the potential for personal gain would make others rightfully question whether her objectivity was being influenced.

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

How do you determine if you are in a conflict of interest, whether actual, apparent, or potential? The key is to determine whether the situation you are in interferes or is likely to interfere with your independent judgment. A good test is the 'trust test': Would relevant others (my employer, my patients, professional colleagues, or the general public) trust my judgment if they knew I was in this situation. Trust is at the ethical heart or core of this issue. Conflicts of interest involve the abuse, actual or potential, of the trust people have placed in professionals. This is why conflicts of interest not only injure particular patients and employers, but they also damage the whole profession by reducing the trust people generally have in therapists.

Case Study #5 – Relationships with Referral Sources

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

Is this an ethical arrangement?

No, this agreement is not ethical. The most notable infraction involves offering to designate (and compensate) the physician as the Medical Director contingent upon the number of referrals he sends. It is perfectly acceptable (and required in some instances) to have a physician as a Medical Director; however, compensating the Medical Director based on their referral volume is unethical. Another area of concern is the rent. At first glance, the rent amount of $17/sq. ft.

seems fair because it was a compromise between the two parties. However, closer scrutiny reveals this to be unethical. The fair market value for rent has been established as $20/sq. ft. (Larry's current rental agreement with his landlord) By discounting the doctor $3/sq. ft. on his rent, Larry is giving a referral source something of value. It is unethical for an occupational therapist to offer anything of value to physicians or any other referral source in direct response for the referral of patients or services. This includes cash, rebates, gifts, discounts, reduced rent, services, equipment, employees, or marketing. Many mistakenly believe that it is a normal acceptable business practice to offer these things to referral sources. It is not. In most states, the practice is not only unethical, but it is also illegal. Exchanges of valued items or services between therapists and referral sources must never have any relationship to the referral of patients. Goodwill gifts of nominal value are acceptable provided that no correlation can be made between the magnitude or frequency of the gift giving and referral patterns. All business agreements and transactions should always be well documented and most importantly, reflect fair market value.

Supplemental Information

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Ethics & Jurisprudence - Utah 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. Utah licensed OTs & OTAs must complete __ hours of continuing education each licensure period; including a minimum of __ hours related to ethical and legal practice. (p. 14)
   A. 30; 3
   B. 24; 3
   C. 24; 2
   D. 20; 2

9. Which of the following statements regarding Utah OT supervision requirements is INCORRECT? (p. 18-19)
   A. An OTA may contribute to and maintain an individual treatment plan.
   B. An OT aide may only perform occupational therapy services under the direct supervision of an OT or OTA.
   C. An OT who supervises an OTA must meet face-to-face with them at least one time per week.
   D. An OT may supervise no more than 2 full-time OTAs at one time.

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

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