

Ethics – Illinois Physical Therapy

Goals & Objectives

Course Description

“Ethics – Illinois Physical Therapy” is an online continuing education course for Illinois licensed physical therapists and physical therapist assistants. The course focuses on defining moral, ethical, and legal behavior of physical therapy professionals. The information presented includes the APTA’s Code of Ethics, Standards for Professional Conduct for Physical Therapist Assistants, model for ethical decision making, the Illinois Physical Therapy Practice Act (225 ILCS 90/), the Illinois Physical Therapy Rules (Title 68, Chapter VII, Subchapter b, Part 1340), and hypothetical case analysis.

Course Rationale

This course is designed to educate, promote and facilitate ethical and legal behavior by Illinois licensed physical therapist and physical therapist assistants. It is intended to fulfill the 3 hour Ethics continuing education requirement of Section 1340.61 of the Illinois Physical Therapy Rules.

Course Goals & Objectives

At the end of this course, the participants will be able to:

1. define the meaning of Ethics and explain the various theories that promote ethical behavior.
2. recognize the principles of APTA’s Code of Ethics for physical therapists and apply them to practical situations
3. recognize the principles of the APTA’s Standards of Ethical Conduct for the PTA and apply them to practical situations
4. define the principles of the ethical decision making model
5. apply the ethical decision making model to clinical situations to determine appropriate professional behavior
6. recognize all of the legal rights and responsibilities of physical therapy licensure as defined by the Illinois Physical Therapy Practice Act and the Illinois Physical therapy Practice Act Rules

Course Provider – Innovative Educational Services

Course Instructor - Michael Niss, DPT

Target Audience – Illinois licensed physical therapists and physical therapist assistants

Course Educational Level - This course is applicable for introductory learners.

Course Prerequisites – None

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

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

Continuing Education Credits - Three (3) hours of continuing education credit

Fees - \$14.95

Conflict of Interest – No conflict of interest exists for the instructor 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 - Illinois Physical Therapy

Course Outline

	page	
Course Goals and Objectives	1	start hour 1
Course Outline	2	
Ethics Overview	3	
Ethics Theories	3-5	
Model for Ethical Decision Making	5-6	
APTA Code of Ethics	6-10	
APTA's Guide for Professional Conduct	10-14	end hour 1
Standards of Ethical Conduct for the PTA	14-17	start hour 2
APTA's Guide for Conduct of the PTA	17-18	
Informed Consent	18-21	
Relationships	21-23	
Gifts and Conflicts of Interest	23-24	
Confidentiality	24-25	end hour 2
Illinois Physical Therapy Practice Act	25-28	start hour 3
225ILCS 90/2	25-26	
225ILCS 90/17	26-28	
225ILCS 90/31	28	
Illinois Physical Therapy Rules	28-35	
Renewals	28-29	
Continuing Education	29-33	
Unprofessional Conduct	33-34	
Advertising	34-35	
Intramuscular Manual Therapy	35-36	
Ethics Case Studies	37-40	
Case #1 – Confidentiality	37	
Case #2 – Informed Consent	37-38	
Case #3 – Medical Necessity	38-39	
Case #4 – Conflicts of Interest	39	
Case #5 – Relationships	39-40	
References	41	
Post-Test	42-43	end hour 3

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 (“science” according to some definitions) that examines the bases of human goals and the foundations of “right” and “wrong” human actions that further or hinder these goals.

Ethics are important on several levels.

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

Ethics vs. Morals

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

Ethical Questions

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

Ethics Theories

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

Utilitarianism

This philosophical theory develops from the work of Jeremy Bentham and John Stewart Mill. Simply put, utilitarianism is the theory that right and wrong is determined by the consequences. The basic tool of measurement is pleasure (Bentham) or happiness (Mill). A morally correct rule was the one that provided the greatest good to the greatest number of people.

Social Contract Theory

Social contract theory is attributed to Thomas Hobbes, John Locke, and from the twentieth century, John Rawls. Social contract theories believe that the moral code is created by the people who form societies. These people come together to create society for the purpose of protection and gaining other benefits of social cooperation. These persons agree to regulate and restrict their conduct to achieve this end.

Deontological or Duty Theory

Under this theory you determine if an act or rule is morally right or wrong if it meets a moral standard. The morally important thing is not consequences but the way choosers think while they make choices. One famous philosopher who developed such a theory was Immanuel Kant (1724-1804).

Ethical Intuitionism

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

Ethical Egoism

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

Natural Law Theory

This is a moral theory which claims that just as there are physical laws of nature, there are moral laws of nature that are discoverable. This theory is largely associated with Aristotle and Thomas Aquinas, who advocated that each thing has its own inherent nature, i.e. characteristic ways of behavior that belong to all members of its species and are appropriate to it. This nature determines what is good or bad for that thing. In the case of human beings, the moral laws of nature stem from our unique capacity for reason. When we act against our own reason, we are violating our nature, and therefore acting immorally.

Virtue Ethics

This ethics theory proposes that ethical behavior is a result of developed or inherent character traits or virtues. A person will do what is morally right because they are a virtuous person. Aristotle was a famous exponent of this view. Aristotle

felt that virtue ethics was the way to attain true happiness. These are some of the commonly accepted virtues.

Autonomy: the duty to maximize the individual's right to make his or her own decisions.

Beneficence: the duty to do good.

Confidentiality: the duty to respect privacy of information.

Finality: the duty to take action that may override the demands of law, religion, and social customs.

Justice: the duty to treat all fairly, distributing the risks and benefits equally.

Nonmaleficence: the duty to cause no harm.

Understanding/Tolerance: the duty to understand and to accept other viewpoints if reason dictates.

Respect for persons: the duty to honor others, their rights, and their responsibilities.

Universality: the duty to take actions that hold for everyone, regardless of time, place, or people involved.

Veracity: the duty to tell the truth.

Model for Ethical Decision Making

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

Are my actions legal?

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

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

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

Are my actions ethical?

Professional ethical behavior as it is defined in this context relates to actions that are consistent with the normative standards established or practiced by others in the same profession. For physical therapists and physical therapist assistants, these ethical standards are documented in the APTA's Code of Ethics. All PT's and PTA's, even those who are not members of the APTA, are bound to these guidelines. This is because The APTA Code of Ethics is the accepted and de facto standard of practice throughout the profession.

Are my actions fair?

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

Would my actions be the same if they were transparent to others?

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

APTA Code of Ethics

Preamble

The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA). The purposes of this Code of Ethics are to:

1. Define the ethical principles that form the foundation of physical therapist practice in patient/client management, consultation, education, research, and administration.

2. Provide standards of behavior and performance that form the basis of professional accountability to the public.
3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities.
4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.
5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

This Code of Ethics is built upon the five roles of the physical therapist (management of patients/clients, consultation, education, research, and administration), the core values of the profession, and the multiple realms of ethical action (individual, organizational, and societal).

Physical therapist practice is guided by a set of seven core values: accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility. Unless a specific role is indicated in the principle, the duties and obligations being delineated pertain to the five roles of the physical therapist. Fundamental to the Code of Ethics is the special obligation of physical therapists to empower, educate, and enable those with impairments, activity limitations, participation restrictions, and disabilities to facilitate greater independence, health, wellness, and enhanced quality of life.

Principles

Principle #1:

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

1A. Physical therapists shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

1B. Physical therapists shall recognize their personal biases and shall not discriminate against others in physical therapist practice, consultation, education, research, and administration.

Principle #2:

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

2A. Physical therapists shall adhere to the core values of the profession and shall act in the best interests of patients/clients over the interests of the physical therapist.

2B. Physical therapists shall provide physical therapy services with compassionate and caring behaviors that incorporate the individual and cultural differences of patients/clients.

2C. Physical therapists shall provide the information necessary to allow patients or their surrogates to make informed decisions about physical therapy care or participation in clinical research.

2D. Physical therapists shall collaborate with patients/clients to empower them in decisions about their health care.

2E. Physical therapists shall protect confidential patient/ client information and may disclose confidential information to appropriate authorities only when allowed or as required by law.

Principle #3:

Physical therapists shall be accountable for making sound professional judgments.

3A. Physical therapists shall demonstrate independent and objective professional judgment in the patient's/client's best interest in all practice settings.

3B. Physical therapists shall demonstrate professional judgment informed by professional standards, evidence (including current literature and established best practice), practitioner experience, and patient/client values.

3C. Physical therapists shall make judgments within their scope of practice and level of expertise and shall communicate with, collaborate with, or refer to peers or other health care professionals when necessary.

3D. Physical therapists shall not engage in conflicts of interest that interfere with professional judgment.

3E. Physical therapists shall provide appropriate direction of and communication with physical therapist assistants and support personnel.

Principle #4:

Physical therapists shall demonstrate integrity in their relationships with patients/clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.

4A. Physical therapists shall provide truthful, accurate, and relevant information and shall not make misleading representations.

4B. Physical therapists shall not exploit persons over whom they have supervisory, evaluative or other authority (e.g., patients/clients, students, supervisees, research participants, or employees).

4C. Physical therapists shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.

4D. Physical therapists shall report suspected cases of abuse involving children or vulnerable adults to the appropriate authority, subject to law.

4E. Physical therapists shall not engage in any sexual relationship with any of their patients/clients, supervisees, or students.

4F. Physical therapists shall not harass anyone verbally, physically, emotionally, or sexually.

Principle #5:

Physical therapists shall fulfill their legal and professional obligations.

5A. Physical therapists shall comply with applicable local, state, and federal laws and regulations.

5B. Physical therapists shall have primary responsibility for supervision of physical therapist assistants and support personnel.

5C. Physical therapists involved in research shall abide by accepted standards governing protection of research participants.

5D. Physical therapists shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

5E. Physical therapists who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.

5F. Physical therapists shall provide notice and information about alternatives for obtaining care in the event the physical therapist terminates the provider relationship while the patient/client continues to need physical therapy services.

Principle #6:

Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors.

6A. Physical therapists shall achieve and maintain professional competence.

6B. Physical therapists shall take responsibility for their professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, health care delivery, and technology.

6C. Physical therapists shall evaluate the strength of evidence and applicability of content presented during professional development activities before integrating the content or techniques into practice.

6D. Physical therapists shall cultivate practice environments that support professional development, lifelong learning, and excellence.

Principle #7:

Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society.

7A. Physical therapists shall promote practice environments that support autonomous and accountable professional judgments.

7B. Physical therapists shall seek remuneration as is deserved and reasonable for physical therapist services.

7C. Physical therapists shall not accept gifts or other considerations that influence or give an appearance of influencing their professional judgment.

7D. Physical therapists shall fully disclose any financial interest they have in products or services that they recommend to patients/clients.

7E. Physical therapists shall be aware of charges and shall ensure that documentation and coding for physical therapy services accurately reflect the nature and extent of the services provided.

7F. Physical therapists shall refrain from employment arrangements, or other arrangements, that prevent physical therapists from fulfilling professional obligations to patients/ clients.

Principle #8:

Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally.

8A. Physical therapists shall provide pro bono physical therapy services or support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

8B. Physical therapists shall advocate to reduce health disparities and health care inequities, improve access to health care services, and address the health, wellness, and preventive health care needs of people.

8C. Physical therapists shall be responsible stewards of health care resources and shall avoid overutilization or underutilization of physical therapy services.

8D. Physical therapists shall educate members of the public about the benefits of physical therapy and the unique role of the physical therapist.

APTA's Guide for Professional Conduct

The APTA's Guide for Professional Conduct is produced to assist physical therapists in interpreting the Code of Ethics in matters of professional conduct. The interpretations reflect the opinions, decisions, and advice of the APTA's Ethics and Judicial Committee (EJC).

The following information has been summarized from the APTA's Guide for Professional Conduct:

Respect

Principle 1A addresses the display of respect toward others. Unfortunately, there is no universal consensus about what respect looks like in every situation. For example, direct eye contact is viewed as respectful and courteous in some cultures and inappropriate in others. It is up to the individual to assess the appropriateness of behavior in various situations.

Altruism

Principle 2A reminds physical therapists to adhere to the profession's core values and act in the best interest of patients/clients over the interests of the physical therapist. Often this is done without thought, but sometimes, especially at the end of the day when the physical therapist is fatigued and ready to go home, it is a conscious decision. For example, the physical therapist may need to make a decision between leaving on time and staying at work longer to see a patient who was 15 minutes late for an appointment.

Patient Autonomy

The underlying purpose of Principle 2C is to require a physical therapist to respect patient autonomy. In order to do so, a physical therapist shall communicate to the patient/client the findings of his/her examination, evaluation, diagnosis, and prognosis. A physical therapist must use sound professional judgment in informing the patient/client of any substantial risks of the recommended examination and intervention and must collaborate with the patient/client to establish the goals of treatment and the plan of care. Ultimately, a physical therapist shall respect the patient's/client's right to make decisions regarding the recommended plan of care, including consent, modification, or refusal.

Professional Judgment

Principles 3, 3A, and 3B state that it is the physical therapist's obligation to exercise sound professional judgment, based upon his/her knowledge, skill, training, and experience. Principle 3B further describes the physical therapist's judgment as being informed by three elements of evidence-based practice.

With regard to the patient/client management role, once a physical therapist accepts an individual for physical therapy services he/she is responsible for: the examination, evaluation, and diagnosis of that individual; the prognosis and intervention; re-examination and modification of the plan of care; and the maintenance of adequate records, including progress reports. A physical therapist must establish the plan of care and must provide and/or supervise and direct the appropriate interventions. Regardless of practice setting, a physical therapist has primary responsibility for the physical therapy care of a patient and

must make independent judgments regarding that care consistent with accepted professional standards.

If the diagnostic process reveals findings that are outside the scope of the physical therapist's knowledge, experience, or expertise or that indicate the need for care outside the scope of physical therapy, the physical therapist must inform the patient/client and must refer the patient/client to an appropriate practitioner.

A physical therapist must determine when a patient/client will no longer benefit from physical therapy services. When a physical therapist's judgment is that a patient will receive negligible benefit from physical therapy services, the physical therapist must not provide or continue to provide such services if the primary reason for doing so is to further the financial self-interest of the physical therapist or his/her employer. A physical therapist must avoid overutilization of physical therapy services. See Principle 8C.

Supervision

Principle 3E describes an additional circumstance in which sound professional judgment is required; namely, through the appropriate direction of and communication with physical therapist assistants and support personnel.

Integrity in Relationships

Principle 4 addresses the need for integrity in relationships. This is not limited to relationships with patients/clients, but includes everyone physical therapists come into contact with professionally. For example, demonstrating integrity could encompass working collaboratively with the health care team and taking responsibility for one's role as a member of that team.

Reporting

When considering the application of "when appropriate" under Principle 4C, it is important to know that not all allegedly illegal or unethical acts should be reported immediately to an agency/authority. The determination of when to do so depends upon each situation's unique set of facts, applicable laws, regulations, and policies. Depending upon those facts, it might be appropriate to communicate with the individuals involved. Consider whether the action has been corrected, and in that case, not reporting may be the most appropriate action. Note, however, that when an agency/authority does examine a potential ethical issue, fact finding will be its first step. The determination of ethicality requires an understanding of all of the relevant facts, but may still be subject to interpretation.

Exploitation

Principle 4E is fairly clear – sexual relationships with patients/clients, supervisees or students are prohibited.

Colleague Impairment

The central tenet of Principles 5D and 5E is that inaction is not an option for a physical therapist when faced with the circumstances described. Principle 5D states that a physical therapist shall encourage colleagues to seek assistance or counsel while Principle 5E addresses reporting information to the appropriate authority.

5D and 5E both require a factual determination on your part. This may be challenging in the sense that you might not know or it might be difficult for you to determine whether someone in fact has a physical, psychological, or substance-related impairment. In addition, it might be difficult to determine whether such impairment may be adversely affecting his or her professional responsibilities. Moreover, once you do make these determinations, the obligation under 5D centers not on reporting, but on encouraging the colleague to seek assistance. However, the obligation under 5E does focus on reporting. But note that 5E discusses reporting when a colleague is unable to perform, whereas 5D discusses encouraging colleagues to seek assistance when the impairment may adversely affect his or her professional responsibilities. So, 5D discusses something that may be affecting performance, whereas 5E addresses a situation in which someone is clearly unable to perform. The 2 situations are distinct. In addition, it is important to note that 5E does not mandate to whom you report; it gives you discretion to determine the appropriate authority.

Professional Competence

6A requires a physical therapist to maintain professional competence within one's scope of practice throughout one's career. Maintaining competence is an ongoing process of self-assessment, identification of strengths and weaknesses, acquisition of knowledge and skills based on that assessment, and reflection on and reassessment of performance, knowledge and skills. Numerous factors including practice setting, types of patients/clients, personal interests and the addition of new evidence to practice will influence the depth and breadth of professional competence in a given area of practice.

Professional Growth

6D elaborates on the physical therapist's obligations to foster an environment conducive to professional growth, even when not supported by the organization. The essential idea is that this is the physical therapist's responsibility, whether or not the employer provides support.

Charges and Coding

Principle 7E provides that the physical therapist must make sure that the process of documentation and coding accurately captures the charges for services performed.

Pro Bono Services

The key word in Principle 8A is “or”. If a physical therapist is unable to provide pro bono services he or she can fulfill ethical obligations by supporting organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

Standards of Ethical Conduct for the Physical Therapist Assistant

Standards

Standard #1:

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

1A. Physical therapist assistants shall act in a respectful manner toward each person regardless of age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition, or disability.

1B. Physical therapist assistants shall recognize their personal biases and shall not discriminate against others in the provision of physical therapy services.

Standard #2:

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

2A. Physical therapist assistants shall act in the best interests of patients/clients over the interests of the physical therapist assistant.

2B. Physical therapist assistants shall provide physical therapy interventions with compassionate and caring behaviors that incorporate the individual and cultural differences of patients/ clients.

2C. Physical therapist assistants shall provide patients/clients with information regarding the interventions they provide.

2D. Physical therapist assistants shall protect confidential patient/ client information and, in collaboration with the physical therapist, may disclose confidential information to appropriate authorities only when allowed or as required by law.

Standard #3:

Physical therapist assistants shall make sound decisions in collaboration with the physical therapist and within the boundaries established by laws and regulations.

3A. Physical therapist assistants shall make objective decisions in the patient’s/client’s best interest in all practice settings.

- 3B. Physical therapist assistants shall be guided by information about best practice regarding physical therapy interventions.
- 3C. Physical therapist assistants shall make decisions based upon their level of competence and consistent with patient/client values.
- 3D. Physical therapist assistants shall not engage in conflicts of interest that interfere with making sound decisions.
- 3E. Physical therapist assistants shall provide physical therapy services under the direction and supervision of a physical therapist and shall communicate with the physical therapist when patient/client status requires modifications to the established plan of care.

Standard #4:

Physical therapist assistants shall demonstrate integrity in their relationships with patients/ clients, families, colleagues, students, other health care providers, employers, payers, and the public.

- 4A. Physical therapist assistants shall provide truthful, accurate, and relevant information and shall not make misleading representations.
- 4B. Physical therapist assistants shall not exploit persons over whom they have supervisory, evaluative or other authority (e.g., patients/clients, students, supervisees, research participants, or employees).
- 4C. Physical therapist assistants shall discourage misconduct by health care professionals and report illegal or unethical acts to the relevant authority, when appropriate.
- 4D. Physical therapist assistants shall report suspected cases of abuse involving children or vulnerable adults to the supervising physical therapist and the appropriate authority, subject to law.
- 4E. Physical therapist assistants shall not engage in any sexual relationship with any of their patients/clients, supervisees, or students.
- 4F. Physical therapist assistants shall not harass anyone verbally, physically, emotionally, or sexually.

Standard #5:

Physical therapist assistants shall fulfill their legal and ethical obligations.

- 5A. Physical therapist assistants shall comply with applicable local, state, and federal laws and regulations.
- 5B. Physical therapist assistants shall support the supervisory role of the physical therapist to ensure quality care and promote patient/client safety.
- 5C. Physical therapist assistants involved in research shall abide by accepted standards governing protection of research participants.

5D. Physical therapist assistants shall encourage colleagues with physical, psychological, or substance-related impairments that may adversely impact their professional responsibilities to seek assistance or counsel.

5E. Physical therapist assistants who have knowledge that a colleague is unable to perform their professional responsibilities with reasonable skill and safety shall report this information to the appropriate authority.

Standard #6:

Physical therapist assistants shall enhance their competence through the lifelong acquisition and refinement of knowledge, skills, and abilities.

6A. Physical therapist assistants shall achieve and maintain clinical competence.

6B. Physical therapist assistants shall engage in lifelong learning consistent with changes in their roles and responsibilities and advances in the practice of physical therapy.

6C. Physical therapist assistants shall support practice environments that support career development and lifelong learning.

Standard #7:

Physical therapist assistants shall support organizational behaviors and business practices that benefit patients/clients and society.

7A. Physical therapist assistants shall promote work environments that support ethical and accountable decision-making.

7B. Physical therapist assistants shall not accept gifts or other considerations that influence or give an appearance of influencing their decisions.

7C. Physical therapist assistants shall fully disclose any financial interest they have in products or services that they recommend to patients/clients.

7D. Physical therapist assistants shall ensure that documentation for their interventions accurately reflects the nature and extent of the services provided.

7E. Physical therapist assistants shall refrain from employment arrangements, or other arrangements, that prevent physical therapist assistants from fulfilling ethical obligations to patients/clients.

Standard #8:

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

8A. Physical therapist assistants shall support organizations that meet the health needs of people who are economically disadvantaged, uninsured, and underinsured.

8B. Physical therapist assistants shall advocate for people with impairments, activity limitations, participation restrictions, and disabilities in order to promote their participation in community and society.

8C. Physical therapist assistants shall be responsible stewards of health care resources by collaborating with physical therapists in order to avoid overutilization or underutilization of physical therapy services.

8D. Physical therapist assistants shall educate members of the public about the benefits of physical therapy.

APTA Guide for Conduct of the Physical Therapist Assistant

The following abridged information has been summarized from the APTA's Guide for Conduct of the Physical Therapist Assistant:

Sound Decisions

To fulfill 3C, the physical therapist assistant must be knowledgeable about his or her legal scope of work as well as level of competence. As a physical therapist assistant gains experience and additional knowledge, there may be areas of physical therapy interventions in which he or she displays advanced skills. At the same time, other previously gained knowledge and skill may be lost due to lack of use. To make sound decisions, the physical therapist assistant must be able to self-reflect on his or her current level of competence.

Supervision

Standard 3E goes beyond simply stating that the physical therapist assistant operates under the supervision of the physical therapist. Although a physical therapist retains responsibility for the patient/client throughout the episode of care, this standard requires the physical therapist assistant to take action by communicating with the supervising physical therapist when changes in the patient/client status indicate that modifications to the plan of care may be needed.

Clinical Competence

6A should cause physical therapist assistants to reflect on their current level of clinical competence, to identify and address gaps in clinical competence, and to commit to the maintenance of clinical competence throughout their career. The supervising physical therapist can be a valuable partner in identifying areas of knowledge and skill that the physical therapist assistant needs for clinical competence and to meet the needs of the individual physical therapist, which may vary according to areas of interest and expertise. Further, the physical therapist assistant may request that the physical therapist serve as a mentor to assist him or her in acquiring the needed knowledge and skills.

Documenting Interventions

7D addresses the need for physical therapist assistants to make sure that they thoroughly and accurately document the interventions they provide to patients/clients and document related data collected from the patient/client. The focus of this Standard is on ensuring documentation of the services rendered, including the nature and extent of such services.

Informed Consent

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

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

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

Consent for Multiple Treatments

Although consent is always specific, it is not the same as saying that separate consent is always required for every episode of repeated treatment. When the plan of care for a given diagnosis involves repeated treatments or procedures—for example, a course of diagnostic tests or ongoing therapy—practitioners do not need to obtain consent for each individual episode.

Blanket Consent

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

Moreover, seeking consent “in case” a patient should need some future intervention that is not related to that patient’s current clinical status violates the fundamental ethical norm that patients must make decisions about proposed treatments or procedures in the context of their present situation. As a “patient-centered action,” informed consent involves the contemporaneous bodily integrity, rights, dignity, intelligence, preferences, interests, goals, and welfare. If a patient’s condition changes enough to warrant a change in the plan of care, the practitioner must explain to the patient (or authorized surrogate) how the situation has changed, establish goals of care in light of the new situation, recommend a new plan of care, and obtain informed consent for the new plan or for specific treatment(s) or procedure(s) now recommended.

Notification versus Consent

Informed consent is also different from “notification,” that is, providing general information relevant to patients’ participation in health care. Notification informs patients not only about their rights, but also about organizational activities and processes that shape how care is delivered. Like informed consent, notification serves the goal of respecting patients as moral agents.

Refusing Treatment

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

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

The professional ethical ideal of shared decision making calls for active, respectful engagement with the patient or surrogate. As a prelude to exploring a patient’s refusal of recommended treatment, practitioners should clarify the patient’s (and/or surrogate’s) understanding of the clinical situation and elicit his or her expectations about the course of illness and care. Practitioners should

clarify the goals of care with the patient or surrogate, address expectations for care that may be unrealistic, and work with the patient or surrogate to prioritize identified goals as the foundation for a plan of care.

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

Resisting Treatment

Health care professionals face different concerns when patients who lack decision-making capacity resist treatment for which their authorized surrogates have given consent. When a surrogate consents to treatment on behalf of a patient who lacks decision-making capacity, practitioners are authorized to carry out the treatment or procedure even if the patient actively resists. In such cases, treatment is not being administered over the patient’s refusal because the surrogate has taken the patient’s place in the process of shared decision making and exercised the patient’s decision-making rights. However, practitioners should still be sensitive to patients who resist treatment. They should try to understand the patient’s actions and their implications for treatment. Practitioners should ask themselves why, for example, a patient repeatedly tries to pull out a feeding tube. Is the tube causing physical discomfort? Is the patient distressed because he or she does not understand what is happening?

Resistance to treatment should prompt practitioners to reflect on whether the treatment is truly necessary in light of the established goals of care for the patient, or whether it could be modified to minimize the discomfort or distress it causes. For instance, a patient may resist treatment via one route of administration but not another.

Practitioners should also be alert to the implications of the patient’s resistance for the judgment that he or she lacks decision-making capacity. In some cases, resistance to treatment may be an expression of the patient’s authentic wishes. Decision-making capacity is not an “all or nothing” proposition. Rather, decision-making capacity is task specific. It rests on being able to receive, evaluate, deliberate about and manipulate information, and communicate a decision, which can vary considerably with the decision to be made. A patient may have capacity to make a simple decision but not a more complex one.

When a patient resists, surrogates, family members, or friends may be able to shed light on the patient’s actions and help practitioners identify ways to provide treatment that are less upsetting for the patient. For patients with fluctuating capacity, it may be possible to explore concerns directly with the patient during lucid moments.

Patients who resist treatment present unique challenges for health care practitioners. The root cause of the resistance should be explored, as well as other clinically acceptable alternatives to the proposed treatment.

Relationships

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

Professionalism

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

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

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

Boundaries

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

Legal Aspects

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

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

Other Problematic Relationships

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

Such interactions or activities are ethically problematic when they can reasonably be expected to affect the care received by the individual or by other patients or the practitioner's relationships with his or her colleagues, or when they give the

appearance of doing so. Yet not all behavior that might be considered inappropriate necessarily violates professional obligations.

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

Gifts and Conflict of Interest

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

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

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

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

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

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

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

The social dynamics of the gift relationship, the potential for gifts subtly to bias health care professionals' prescribing practices and clinical decisions, and the obligation of health care professionals to avoid acting in ways that might undermine public trust all argue for the adoption of clear, robust policies regarding the acceptance of gifts from companies. Creating a workplace in which professionals no longer routinely expect or accept gifts from industry is a challenging task that calls for professional role modeling and sustained, coordinated efforts on the part of clinical and administrative leaders, as well as development and careful implementation of clear, well-considered policy.

Confidentiality

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

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

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

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

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

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

Illinois Physical Therapy Practice Act (225 ILCS 90/)

The following is an abridged version of the Illinois Physical Therapy Practice Act (225 ILCS 90/). To read the document in its entirety, please go to: www.idfpr.com/profs/info/PT.asp

225 ILCS 90/2

A physical therapist shall use the initials "PT" in connection with his or her name to denote licensure under this Act, and a physical therapist assistant shall use the initials "PTA" in connection with his or her name to denote licensure under this Act.

This Act does not prohibit:

6. Physical therapy aides from performing patient care activities under the on-site supervision of a licensed physical therapist or licensed physical therapist assistant. These patient care activities shall not include interpretation of referrals, evaluation procedures, the planning of or major modifications of, patient programs.

7. Physical Therapist Assistants from performing patient care activities under the general supervision of a licensed physical therapist. The physical therapist must

maintain continual contact with the physical therapist assistant including periodic personal supervision and instruction to insure the safety and welfare of the patient.

225 ILCS 90/17

Sec. 17. (1) The Department may refuse to issue or to renew, or may revoke, suspend, place on probation, reprimand, or take other disciplinary action as the Department deems appropriate, including the issuance of fines not to exceed \$5000, with regard to a license for any one or a combination of the following:

A. Material misstatement in furnishing information to the Department or otherwise making misleading, deceptive, untrue, or fraudulent representations in violation of this Act or otherwise in the practice of the profession;

B. Violations of this Act, or of the rules or regulations promulgated hereunder

C. Conviction of any crime under the laws of the United States or any state or territory thereof which is a felony or which is a misdemeanor, an essential element of which is dishonesty, or of any crime which is directly related to the practice of the profession; conviction, as used in this paragraph, shall include a finding or verdict of guilty, an admission of guilt or a plea of nolo contendere;

D. Making any misrepresentation for the purpose of obtaining licenses, or violating any provision of this Act or the rules promulgated thereunder pertaining to advertising.

E. A pattern of practice or other behavior which demonstrates incapacity or incompetency to practice under this Act;

F. Aiding or assisting another person in violating any provision of this Act or Rules;

G. Failing, within 60 days, to provide information in response to a written request made by the Department;

H. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public. Unprofessional conduct shall include any departure from or the failure to conform to the minimal standards of acceptable and prevailing physical therapy practice, in which proceeding actual injury to a patient need not be established;

I. Unlawful distribution of any drug or narcotic, or unlawful conversion of any drug or narcotic not belonging to the person for such person's own use or benefit or for other than medically accepted therapeutic purposes;

J. Habitual or excessive use or addiction to alcohol narcotics, stimulants, or any other chemical agent or drug which results in a physical therapist's or physical therapist assistant's inability to practice with reasonable judgment, skill or safety;

K. Revocation or suspension of a license to practice physical therapy as a physical therapist or physical therapist assistant or the taking of other disciplinary action by the proper licensing authority of another state, territory or country;

L. Directly or indirectly giving to or receiving from any person, firm, corporation, partnership, or association any fee, commission, rebate or other form of compensation for any professional services not actually or personally rendered.

Nothing contained in this paragraph prohibits persons holding valid and current licenses under this Act from practicing physical therapy in partnership under a

partnership agreement, including a limited liability partnership, a limited liability company, or a corporation under the Professional Service Corporation Act or from pooling, sharing, dividing, or apportioning the fees and monies received by them or by the partnership, company, or corporation in accordance with the partnership agreement or the policies of the company or professional corporation. Nothing in this paragraph (L) affects any bona fide independent contractor or employment arrangements among health care professionals, health facilities, health care providers, or other entities, except as otherwise prohibited by law. Any employment arrangements may include provisions for compensation, health insurance, pension, or other employment benefits for the provision of services within the scope of the licensee's practice under this Act. Nothing in this paragraph (L) shall be construed to require an employment arrangement to receive professional fees for services rendered;

M. A finding by the Board that the licensee after having his or her license placed on probationary status has violated the terms of probation;

N. Abandonment of a patient;

O. Willfully failing to report an instance of suspected child abuse or neglect as required by the Abused and Neglected Child Reporting Act;

P. Willfully failing to report an instance of suspected elder abuse or neglect as required by the Elder Abuse Reporting Act;

Q. Physical illness, including but not limited to deterioration through the aging process, or loss of motor skill which results in the inability to practice the profession with reasonable judgment, skill or safety;

R. The use of any words (such as physical therapy, physical therapist, physiotherapy or physiotherapist), abbreviations, figures or letters with the intention of indicating practice as a licensed physical therapist without a valid license as a physical therapist issued under this Act;

S. The use of the term physical therapist assistant, or abbreviations, figures, or letters with the intention of indicating practice as a physical therapist assistant without a valid license as a physical therapist assistant issued under this Act;

T. Willfully violating or knowingly assisting in the violation of any law of this State relating to the practice of abortion;

U. Continued practice by a person knowingly having an infectious, communicable or contagious disease;

V. Having treated ailments of human beings otherwise than by the practice of physical therapy as defined in this Act, or having treated ailments of human beings as a licensed physical therapist independent of a documented referral or a documented current and relevant diagnosis from a physician, dentist, advanced practice nurse, physician assistant, or podiatric physician, or having failed to notify the physician, dentist, advanced practice nurse, physician assistant, or podiatric physician who established a documented current and relevant diagnosis that the patient is receiving physical therapy pursuant to that diagnosis;

W. Being named as a perpetrator in an indicated report by the Department of Children and Family Services pursuant to the Abused and Neglected Child Reporting Act, and upon proof by clear and convincing evidence that the licensee

has caused a child to be an abused child or neglected child as defined in the Abused and Neglected Child Reporting Act;

X. Interpretation of referrals, performance of evaluation procedures, planning or making major modifications of patient programs by a physical therapist assistant;

Y. Failure by a physical therapist assistant and supervising physical therapist to maintain continued contact, including periodic personal supervision and instruction, to insure safety and welfare of patients;

Z. Violation of the Health Care Worker Self-Referral Act.

225 ILCS 90/31

Sec. 31. Violations

(a) Any person who is found to have violated any provision of this Act is guilty of a Class A misdemeanor for the first offense and a Class 4 felony for the second and any subsequent offense.

(b) Any person representing himself or herself or advertising as a physical therapist or that the services he or she renders are physical therapy, or who uses any words, such as physical therapy, physical therapist, physiotherapy, or physiotherapist, abbreviations, figures, or letters, such as "PT", "DPT", "MPT", "RPT", "LPT", or "PTA", indicating that he or she is engaged in the practice of physical therapy when he or she does not possess a currently valid license as defined herein, commits a Class A misdemeanor, for a first offense, and a Class 4 felony for a second or subsequent offense.

(c) Any person representing himself or herself or advertising as a physical therapist assistant or that the services he or she renders are physical therapy, or who uses any words, such as physical therapy or physical therapist assistant, abbreviations, figures, or letters, such as "PT", "DPT", "MPT", "RPT", "LPT", or "PTA", indicating that he or she is engaged in the practice of physical therapy when he or she does not possess a currently valid license as defined herein, commits a Class A misdemeanor for a first offense, and a Class 4 felony for a second or subsequent offense.

Illinois Physical Therapy Rules (Title 68, Chapter VII, Subchapter b, Part 1340)

The following is an abridged version of the Illinois Physical Therapy Rules. To read the document in its entirety, please go to: <https://www.ilga.gov/commission/jcar/admincode/068/06801340sections.html>

Section 1340.55 Renewals

a) Every physical therapy license issued under the Act shall expire on September 30 of each even-numbered year. Every physical therapist assistant license issued under the Act shall expire on September 30 of each odd-numbered year. The holder of a license may renew the license during the month preceding the expiration date of the license by paying the required fee and completing continuing education (CE) as set forth in Section 1340.61.

- b) It is the responsibility of each licensee to notify the Division of any change of address. Failure to receive a renewal form from the Division shall not constitute an excuse for failure to renew a license or pay the renewal fee.
- c) Practicing or offering to practice on a license that has expired shall be considered unlicensed activity and shall be grounds for discipline as set forth in Section 31 of the Act.

Section 1340.61 Continuing Education

a) CE Hour Requirements

- 1) Every physical therapist shall complete 40 hours of CE relevant to the practice of physical therapy during each prerenewal period as a condition of renewal. Beginning with the September 2016 renewal, at least 3 hours of the 40 hours must include content related to the ethical practice of physical therapy.
- 2) Every physical therapist assistant shall complete 20 hours of CE relevant to the practice of physical therapy during each prerenewal period as a condition of renewal. Beginning with the September 2017 renewal, at least 3 hours of the 20 hours must include content related to the ethical practice of physical therapy.
- 3) A prerenewal period is the 24 months preceding September 30 in the year of the renewal.
- 4) A CE hour equals 50 minutes. After completion of the initial CE hour, credit may be given in one-half hour increments.
- 5) Courses that are part of the curriculum of a university, college or other educational institution shall be allotted CE credit at the rate of 15 CE hours for each semester hour or 10 CE hours for each quarter hour of academic credit awarded.
- 6) A renewal applicant is not required to comply with CE requirements for the first renewal following the original issuance of the license.
- 7) Physical therapists and physical therapist assistants licensed in Illinois but residing and practicing in other states must comply with the CE requirements set forth in this Section. CE credit hours used to satisfy the CE requirements of another state may be submitted for approval for fulfillment of the CE requirements of the State of Illinois if the CE requirements in the other state are equivalent to the CE requirements in this Section.

b) Approved CE

- 1) All CE activities shall be relevant to the advancement, extension and enhancement of providing patient/client management, including but not limited to physical therapy examination, evaluation, intervention, and prevention and providing physical therapy services or fulfilling the other professional roles of a physical therapist or physical therapist assistant. Courses not acceptable for the purpose of this definition include, but are not limited to, personal estate planning, personal financial planning, personal investments, and personal health.

2) CE hours may be earned by verified attendance at or participation in a program that is offered by an approved CE sponsor who meets the requirements set forth in subsection (c). Credit shall not be given for courses taken in Illinois from unapproved sponsors.

3) CE may also be earned from the following activities:

A) Teaching a course for an approved CE sponsor or a CAPTE accredited PT or PTA program. An applicant will receive 2 hours of credit for each CE hour awarded to course attendees the first time the course is taught and 1 hour of credit for each CE hour the second time the same course is taught; no credit will be given for teaching the same course 3 or more times. A maximum of 50% of the total CE requirements may be earned through CE instruction. The applicant must be able to provide verification of unique content for each CE course taught via course goals, objectives, and outline.

B) American Board of Physical Therapy Specialties (ABPTS) Clinical Specialist Certification. An applicant will receive 40 hours of CE credit for the prerenewal period in which the initial certification is awarded.

C) American Physical Therapy Association (APTA)-approved post-professional clinical residency or fellowship. An applicant will receive 1 hour of CE credit for every 2 hours spent in clinical residency, up to a maximum of 20 hours. Clinical residency hours may not be used for CE credit if the applicant is also seeking CE credit for hours earned for post-professional academic coursework in the same prerenewal period.

D) Professional research/writing. An applicant may receive CE credit for publication of scientific papers, abstracts, or review articles in peer-reviewed and other professional journals; publication of textbook chapters; and poster or platform presentations at conferences sponsored by any entity that has preapproved status, up to a maximum of 50% of the total CE requirements:

- i) 15 hours for each refereed article.
- ii) 3 hours for each non-refereed article, abstract of published literature or book review.
- iii) 5 hours for each textbook chapter.
- iv) 5 hours for each poster or platform presentation or review article.

E) Self-study. A maximum of 50% of the total CE requirements may be earned through the following self-study activities

- i) An applicant may obtain CE credit by taking correspondence or web-based courses, including pre-recorded professional presentations and pre-recorded webinars, from an approved CE sponsor. These courses

shall include a test that must be passed in order to obtain credit.

ii) An applicant can receive CE credit for completion of published tests/quizzes based on APTA publications. The applicant will be responsible for verifying successful completion. (These publication-based tests/quizzes, typically offered for less than 1 hour of CE credit, are the only exception to the requirement that all approved CE activities must be at least 1 hour.)

F) Journal clubs. Up to 5 hours of CE credit may be obtained for participation in a journal club. Credit will be earned based on actual hours of participation and must be verified with an attendance list and list of articles from peer-reviewed journals discussed at each meeting.

G) Educational programs at Illinois Physical Therapy Association (IPTA) district meetings. Up to 5 hours of CE credit may be obtained for attendance at these programs. Credit will be earned based on actual hours of participation and must be verified with an attendance list and referenced presentation materials.

H) Departmental inservices. Up to 5 hours of CE credit may be obtained for attendance at inservices at healthcare facilities or organizations. Credit will be earned based on actual hours of participation and must be verified with an attendance list and referenced presentation materials.

I) Up to 5 CE hours may be earned for completion of skills certification courses. A maximum of 2 hours in cardiopulmonary resuscitation certified by the American Red Cross, American Heart Association, or other qualified organization may be accepted, while a maximum of 3 hours may be accepted for certification or recertification in Basic Life Support for Healthcare Providers (BLS), Advanced Cardiac Life Support (ACLS), or Pediatric Advanced Life Support (PALS) or their equivalent.

J) Clinical instructor. Up to 5 hours of CE credit may be obtained by being a clinical instructor for PTA students and up to 10 hours of CE credit may be obtained by being a clinical instructor for PT students. Credit will be earned based on hours of cumulative student clinical instruction, with 1 hour of CE credit per 120 student hours. CE credit hours for clinical instruction will be awarded by the student's academic institution.

K) Virtual attendance at live professional presentations, provided the participant is able to communicate in real time with the speaker and other participants. This shall not be considered self-study under subsection (b)(3)(E).

4) CE will not be awarded for the following types of activities:

- A) Entry-level physical therapist or physical therapist assistant academic coursework.
 - B) Employee orientation programs.
 - C) Professional meetings or conventions, other than educational programming by approved sponsors.
 - D) Committee meetings.
 - E) Work experience.
 - F) Individual scholarship, mass media programs or self-study activities not identified in subsection (b)(2)(E).
- c) CE Sponsors and Programs
- 1) Approved sponsor, as used in this Section, shall mean:
 - A) APTA and its components, including programs, courses and activities approved by the IPTA;
 - B) Federation of State Boards of Physical Therapy, including programs, courses and activities approved through its ProCert program;
 - C) Colleges, universities, or community colleges or institutions with physical therapist or physical therapist assistant education programs accredited by the Commission on Accreditation in Physical Therapy Education; for post-professional academic coursework, all regionally accredited colleges and universities would be approved sponsors; and
 - D) Any other person, firm, association, corporation, or group that has been approved and authorized by the Division pursuant to subsection (c)(2) upon the recommendation of the Board to coordinate and present CE courses or programs.
- d) CE Earned in Other Jurisdictions
- 1) If a licensee has earned CE hours in another jurisdiction from a nonapproved sponsor for which he/she will be claiming credit toward full compliance in Illinois, that applicant shall submit an application along with a \$20 processing fee prior to taking the program or 90 days prior to the expiration date of the license. The Division or the Board shall review and recommend approval or disapproval of this program using the criteria set forth in this Section.
 - 2) If a licensee fails to submit an out of state CE approval form within the required time, late approval may be obtained by submitting the application with the \$20 processing fee plus a \$10 per CE hour late fee not to exceed \$150. The Division or the Board shall review and recommend approval or disapproval of this program using the criteria set forth in this Section.
- e) Certification of Compliance with CE Requirements
- 1) Each renewal applicant shall certify, on the renewal application, full compliance with CE requirements set forth in subsection (a).
 - 2) The Division may require additional evidence demonstrating compliance with the CE requirements. It is the responsibility of each renewal applicant to retain or otherwise produce evidence of compliance for a minimum of 5 years.

- 3) When there appears to be a lack of compliance with CE requirements, an applicant will be notified and may request an interview with the Board, at which time the Board may recommend that steps be taken to begin formal disciplinary proceedings as required by Section 10-65 of the Illinois Administrative Procedure Act [5 ILCS 100/10-65].
- f) Waiver of CE Requirements
- 1) Any renewal applicant seeking renewal of his/her license without having fully complied with these CE requirements shall file with the Division a renewal application, the renewal fee set forth in Section 1340.57, a statement setting forth the facts concerning the noncompliance, and a request for waiver of the CE requirements on the basis of those facts. If the Division, upon the written recommendation of the Board, finds from the affidavit or any other evidence submitted that good cause has been shown for granting a waiver, the Division shall waive enforcement of the CE requirements for the renewal period for which the applicant has applied.
 - 2) Good cause shall be defined as an inability to devote sufficient hours to fulfilling the CE requirements during the applicable prerenewal period because of:
 - A) Full-time service in the armed forces of the United States of America during a substantial part of the prerenewal period; or
 - B) Extreme hardship shall be determined on an individual basis by the Board and be defined as an inability to devote sufficient hours to fulfilling the CE requirements during the applicable prerenewal period because of:
 - i) A temporary incapacitating illness documented by a statement from a currently licensed physician. A CE waiver under this subsection (f) may only be granted for one renewal period and shall not be granted for any subsequent period;
 - ii) Temporary undue hardship (e.g., prolonged hospitalization, being disabled and unable to practice physical therapy on a temporary basis).
 - 3) If an interview with the Board is requested at the time the request for the waiver is filed with the Division, the renewal applicant shall be given at least 20 days written notice of the date, time and place of the interview by certified mail, return receipt requested.
 - 4) Any renewal applicant who submits a request for waiver pursuant to subsection (f)(1) shall be deemed to be in good standing until the Division's final decision on the application has been made.

Section 1340.65 Unprofessional Conduct

- a) Pursuant to Section 17(I)(H) of the Act, unprofessional conduct in the practice of physical therapy shall include, but not be limited to:

- 1) 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.
 - 2) 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.
 - 3) Revealing of personally identifiable facts, data or information about a patient or client obtained in a professional capacity without the prior consent of the patient or client, except as authorized or required by law.
 - 4) 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.
 - 5) Delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that the person to whom the responsibilities were delegated is not qualified by training, experience, or licensure to perform them.
 - 6) Failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of a licensed physical therapist.
 - 7) Overutilizing services by providing excessive evaluation or treatment procedures not warranted by the condition of the patient or by continuing treatment beyond the point of possible benefit.
 - 8) Making gross or deliberate misrepresentations or misleading claims as to professional qualifications or of the efficacy or value of the treatments or remedies given or recommended, or those of another practitioner.
 - 9) Gross and willful and continued overcharging for professional services, including filing false statements for collection of fees for which services are not rendered.
 - 10) Failing to maintain a record for each patient that accurately reflects the evaluation and treatment of the patient.
 - 11) Advertising or soliciting for patronage in a manner that is fraudulent or misleading. Examples of advertising or soliciting which is considered fraudulent or misleading, for example advertising that contains false, fraudulent, deceptive or misleading materials, warranties or guarantees of success, statements that play upon vanities or fears of the public, or statements that promote or produce unfair competition.
- b) The Division hereby incorporates by reference the "Code of Ethics", July 2010, approved by the American Physical Therapy Association, 1111 North Fairfax Street, Alexandria VA 22314, with no later amendments or editions.

Section 1340.66 Advertising

- a) Persons licensed to practice physical therapy in the State of Illinois may advertise in any medium or other form of public communications in a manner which presents information to the public in a truthful, direct, dignified and readily comprehensible manner.

b) If an advertisement is communicated to the public over television or radio, it shall be prerecorded and approved for broadcast by the licensee and a recording of the actual transmission, including videotape, shall be retained by the licensee for 3 years.

c) Information which may be contained in advertising shall include, but not be limited to:

- 1) Licensee's name, address, office hours and telephone number;
- 2) Schools attended;
- 3) Announcement of additions to or deletions from professional staff;
- 4) Announcement of the opening of, change of, or return to practice;
- 5) Professional memberships;
- 6) Credit arrangements and/or acceptance of Medicare/Medicaid patients and credit cards;
- 7) Foreign language ability;
- 8) Usual and customary fees for routine professional services which must include a statement that fees may be adjusted due to complications or unforeseen circumstances; and
- 9) Description of offices in which licensee practices, e.g., accessibility to the disabled, convenience of parking.

d) Information which may be untruthful, fraudulent, deceptive or misleading includes, but is not limited to, that which:

- 1) Contains an offer to treat patients independent of referrals or a current and relevant diagnosis from a physician, dentist or podiatrist;
- 2) Contains a misrepresentation of fact or omits a material fact required to prevent deception;
- 3) Guarantees favorable results or creates false or unjustified expectations of favorable results;
- 4) Takes advantage of the potential client's fears, anxieties, vanities, or other emotions;
- 5) Contains exaggerations pertaining to the quality of physical therapy care;
- 6) Describes as available products or services which are not permitted by the laws of this State or applicable Federal laws; and
- 7) Advertises professional services which the licensee is not licensed to render.

Section 1340.75 Intramuscular Manual Therapy

a) A physical therapist licensed to practice in the State of Illinois may only perform intramuscular manual therapy under the following conditions.

- 1) Prior to completion of the education under subsection (a)(2), successful completion of a total of 50 hours of instruction in the following areas:
 - A) the musculoskeletal and neuromuscular system;
 - B) the anatomical basis of pain mechanisms, chronic pain and referred pain;
 - C) myofascial trigger point theory; and
 - D) universal precautions.

- 2) Completion of at least 30 hours of didactic course work specific to intramuscular manual therapy. This requirement can be fulfilled by the didactic pre-study required for the intramuscular manual therapy practicum course.
 - 3) Successful completion of at least 54 practicum hours in intramuscular manual therapy course work approved by the Federation of State Boards of Physical Therapy or its successor (or substantial equivalent), as determined by the Department. Each instructional course shall specify what anatomical regions are included in the instruction and describe whether the course offers introductory or advanced instruction in intramuscular manual therapy. Each instruction course shall include the following areas:
 - A) intramuscular manual therapy technique;
 - B) intramuscular manual therapy indications and contraindications;
 - C) documentation of intramuscular manual therapy;
 - D) management of adverse effects;
 - E) practical psychomotor competency; and
 - F) the Occupational Safety and Health Administrations Bloodborne Pathogens standard.
 - 4) Postgraduate classes qualifying for completion of the mandated 54 hours of intramuscular manual therapy shall be in one or more modules, with the initial module being no fewer than 27 hours. Therapists shall complete at least 54 hours in no more than 12 months.
 - 5) Completion of at least 200 patient treatment sessions under general supervision recognized by the American Physical Therapy Association.
 - 6) Successful completion of a competency examination approved by the Division. The Division will accept competency examinations administered as part of the intramuscular manual therapy practicum course work.
- b) Each licensee is responsible for maintaining records of the completion of the requirements of this subsection (a) and shall be prepared to produce those records upon request by the Division
 - c) A newly-licensed physical therapist shall not practice intramuscular manual therapy for at least one year from the date of initial licensure unless the practitioner can demonstrate compliance with subsection (a) through his or her prelicensure educational coursework.
 - d) Intramuscular manual therapy may only be performed by a licensed physical therapist and may not be delegated to a physical therapist assistant or support personnel.
 - e) A physical therapist shall not advertise, describe to patients or the public, or otherwise represent that dry needling is acupuncture, nor shall he or she represent that he or she practices acupuncture unless separately licensed under the Acupuncture Practice Act [225 ILCS 2].

Ethics Case Studies

Case Study #1 - Confidentiality

John Jones PT, Sue Brown (therapy receptionist), and Mary Smith (Marketing Director), are in a private PT office discussing the fact that they are treating Biff Simpson, a star NFL quarterback. John says, "I can't believe that I'm actually treating Biff Simpson." Mary asks, "How bad do you think his injury is?" John replies, "I saw his MRI report, it looks like he is going to need surgery."

Is this a breach in confidentiality?

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

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

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

Case Study #2 – Informed Consent

Sam is a PT who has just received orders to begin ambulation with a 75-year-old woman who is s/p right hip ORIF. He goes to her hospital room to evaluate her and begin ambulation. She says she does not want therapy today because she is in too much pain. Sam explains to her that the doctor has left orders for her to begin walking. The patient refuses. Sam leaves and returns the next day to try again. Again, she declines treatment and he 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 of 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. 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 is a physical therapist and owns his own therapy clinic. He recently signed a contract with an HMO to provide physical therapy services. The contract stipulates that Steve will be compensated on a case rate basis. (A fixed amount of money per patient, based on diagnosis) Steve has performed a thorough cost analysis on this contract and has determined that the financial "breakeven" point

(revenue equals expenses) on each of these patients is 5 visits. He informs his staff that all patients covered by this insurance must be discharged by their fourth visit.

Is limiting care in this manner ethical?

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

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

Case Study #4 – Conflicts of Interest

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

Does this represent a conflict of interest?

Yes, there exists a conflict of interest in this situation. Debi has two primary obligations to fulfill. The first is to her patient. It is her professional duty to recommend to her patient a brace that, in her judgment, will benefit them the most. The second obligation is to her employer, the hospital. As an employee of the hospital it is her responsibility to manage expenses by thoroughly and objectively seeking effective products that also demonstrate economic efficiency. The conflict of interest occurs when she begins to accept compensation from the vendor in direct or indirect response for her brace orders. Even if she truly believes it is the best brace for her patient, and it is the most cost effective brace the hospital could purchase, by accepting the money she has established at least an apparent conflict of interest. Under this situation she is obligated to disclose to all parties her financial interest in ordering the braces. This disclosure is necessitated because the potential for personal gain would make others rightfully question whether her objectivity was being influenced.

Case Study #5 – Relationships with Referral Sources

Larry Jones PT owns a private practice. Business has been poor. He decides to sublease half of his space to an orthopedic surgeon. Larry's current lease is at \$20/sq ft. The doctor wants to pay \$15/sq ft. They come to a compromise of

\$17/sq ft. Larry also agrees that if the doctor is his top referral source after 3 months, he'll make him the Medical Director of the facility and pay him a salary of \$500/month.

Is this an ethical arrangement?

No, this agreement is not ethical. The most notable infraction involves offering to designate 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 a physical therapist to offer anything of value to physicians or any other referral source in direct response for the referral of patients or services. This includes cash, rebates, gifts, discounts, reduced rent, services, equipment, employees, or marketing. Many mistakenly believe that it is a normal acceptable business practice to offer these things to referral sources. It is not. In most states, the practice is not only unethical, but it is also illegal. Exchanges of valued items or services between therapists and referral sources must never have any relationship to the referral of patients. Goodwill gifts of nominal value are acceptable provided that no correlation can be made between the magnitude or frequency of the gift giving and referral patterns. All business agreements and transactions should always be well documented and most importantly, reflect fair market value.

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17064

Ethics - Illinois Physical Therapy

Post-Test

1. Which ethics theory is stated INCORRECTLY? (p. 3-5)
 - A. Utilitarianism is the theory that right and wrong is determined by consequence.
 - B. Social Contract Theory proposes that moral code is created by the people who form societies.
 - C. Ethical Egoism is based on the theory that each person should do whatever promotes their own best interests.
 - D. Natural Law Theory proposes that ethical behavior is a result of inherent character traits.

2. Which of the following statements is TRUE? (p. 5-6)
 - A. All actions that are legal are also morally right.
 - B. All actions that are morally right are also legal.
 - C. Physical therapy ethics vary state by state.
 - D. The APTA Code of Ethics establishes ethical behavior for all physical therapists; including therapists who are not members of the APTA.

3. Which of the following is NOT one of the stated purposes of the APTA's Code of Ethics? (p. 6-7)
 - A. Provide standards of behavior and performance that form the basis of professional accountability to the public.
 - B. Establish rules that define lawful physical therapy practice.
 - C. Provide guidance for physical therapists facing ethical challenges.
 - D. Establish standards by which the APTA can determine if a physical therapist has engaged in unethical conduct.

4. As per the principles of the APTA's Code of Ethics, it is unethical for a physical therapist to have a sexual relationship with _____. (p. 6-10)
 - A. their patient
 - B. a PTA working under their supervision
 - C. their physical therapy student intern
 - D. All of the above

5. According to the Standards of Ethical Conduct for the Physical Therapist Assistant, physical therapist assistants shall provide physical therapy services under the direction and supervision of a _____. (p. 14-17)
 - A. physical therapist
 - B. physical therapist or physician
 - C. physical therapist, physician, or other qualified health care professional
 - D. None of the above

6. What is the most important role of informed consent? (p. 18-21)
 - A. Protect the health care provider against possible liability.
 - B. The patient has an opportunity to be an informed participant in their health care decisions.
 - C. Establish an authoritative chain of command.
 - D. None of the above.

7. PT professionals are expected to make a “fiduciary” commitment to their patients. This means that they will _____. (p. 21-23)
 - 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

8. As per the Illinois Physical Therapy Practice Act, a physical therapist assistant must practice under the _____ supervision of a licensed physical therapist who maintains _____ contact with the PTA. (p. 25-28)
 - A. general; continuous
 - B. on-site; occasional
 - C. direct; daily
 - D. indirect; weekly

9. Which of the following is TRUE regarding Illinois physical therapy continuing education requirements? (p. 29-33)
 - A. Licensees must complete at least 3 hours of education related to the ethical practice of physical therapy each licensure period.
 - B. A maximum of 50% of the total CE requirement may be earned through self-study.
 - C. Virtual attendance of live interactive online webinars is NOT classified as self-study.
 - D. All of the above

10. It is unethical for a physical therapist to _____. (p. 39-40)
 - A. have a physician as a medical director
 - B. sublease office space to a potential referral source
 - C. waive the insurance co-pay for the spouse of a referring physician
 - D. meet with a physician to educate them about new physical therapy techniques and interventions.

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