

Ethics and Jurisprudence – Wisconsin Physical Therapy

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Goals & Objectives

Course Description

“Ethics and Jurisprudence” is an online continuing education course for Wisconsin 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 discussions on the theoretical basis for ethical decision-making, the Wisconsin Physical Therapy Practice Act, the Wisconsin Physical Therapy Examining Board Rules, the APTA’s Code of Ethics, the APTA’s Standards of Ethical Conduct for the Physical Therapist Assistant, informed consent, conflict of interest, and hypothetical case studies.

Course Rationale

This course is presented to fulfill the Ethics/Jurisprudence CE requirements of PT 9.03(1) & (2) of the Wisconsin Administrative Code, Board of Physical Therapy Rules. Its purpose is to educate, promote and facilitate ethical and legal behavior by Wisconsin licensed physical therapists and physical therapist assistants.

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. identify the steps required for a systemic approach to ethical decision-making.
3. recognize the rights and responsibilities of physical therapy licensure as defined by the Wisconsin Physical Therapy Practice Act (Chapter 448, Subchapter III) and the Wisconsin Rules Governing the Practice of Physical Therapy
4. recognize the principles of the APTA’s Code of Ethics and Guide for Professional Conduct
5. analyze and interpret clinical situations to determine appropriate professional ethical behavior.
6. define the parameters of informed consent
7. differentiate between appropriate and inappropriate relationships

Course Provider – Innovative Educational Services

Course Instructor - Michael Niss, DPT

Target Audience – Wisconsin 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 - Four (4) hours of continuing education credit

Fees - \$19.95

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.

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Ethics Overview

The word “ethics” is derived from the Greek word *ethos* (character). In philosophy, ethics defines what is good for the individual and for society and establishes the nature of duties that people owe themselves and one another. Ethics is also a field of human inquiry (“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.

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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

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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?

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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.

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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.

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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.

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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.

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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).

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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

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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.

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- 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.

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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.

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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

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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.

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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.

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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.

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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.

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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.

Wisconsin Statutes Chapter 448, Subchapter III - Abridged (Wisconsin Physical Therapy Statutes)

To read the statutes in their entirety, please go to: <https://docs.legis.wisconsin.gov/document/statutes/448.50>

448.50 Definitions.

448.50(1r)

“Diagnosis” means a judgment that is made after examining the neuromusculoskeletal system or evaluating or studying its symptoms and that utilizes the techniques and science of physical therapy for the purpose of establishing a plan of therapeutic intervention, but does not include a chiropractic or medical diagnosis.

448.50(3)

“Physical therapist” means an individual who has been graduated from a school of physical therapy and holds a license to practice physical therapy granted by the examining board or who holds a physical therapist compact privilege.

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448.50(3m)

"Physical therapist assistant" means an individual who holds a license as a physical therapist assistant granted by the examining board or who holds a physical therapist assistant compact privilege.

448.50(4)

(a) "Physical therapy" means, except as provided in par. (b), any of the following:

1. Examining, evaluating, or testing individuals with mechanical, physiological, or developmental impairments, functional limitations related to physical movement and mobility, disabilities, or other movement-related health conditions, in order to determine a diagnosis, prognosis, or plan of therapeutic intervention or to assess the ongoing effects of intervention. In this subdivision, "testing" means using standardized methods or techniques for gathering data about a patient.
2. Alleviating impairments or functional limitations by instructing patients or designing, implementing, or modifying therapeutic interventions.
3. Reducing the risk of injury, impairment, functional limitation, or disability, including by promoting or maintaining fitness, health, or quality of life in all age populations.
4. Engaging in administration, consultation, or research that is related to any activity specified in subds. 1. to 3.

(b) "Physical therapy" does not include any of the following:

1. Using roentgen rays or radium for any purpose, except that "physical therapy" includes ordering X-rays to be performed by qualified persons, subject to s. 448.56 (7) (a), and using X-ray results to determine a course of care or to determine whether a referral to another health care provider is necessary.
2. Using electricity for surgical purposes, including cauterization.
3. Prescribing drugs or devices.

448.50(5)

"Sexual misconduct with a patient" means any of the following:

- (a) Engaging in or soliciting a consensual or nonconsensual sexual relationship with a patient.
- (b) Making sexual advances toward, requesting sexual favors from, or engaging in other verbal conduct or physical contact of a sexual nature with a patient.
- (c) Intentionally viewing a completely or partially disrobed patient during the course of treatment if the viewing is not related to diagnosis or treatment.

448.50(6)

"Therapeutic intervention" means the purposeful and skilled interaction between a physical therapist, patient, and, if appropriate, individuals involved in the patient's care, using physical therapy procedures or techniques that are intended to produce changes in the patient's condition and that are consistent with diagnosis and prognosis.

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Physical therapists and massage therapists are not prohibited from performing the activities that are within their respective scopes of practice, even if those activities extend in some degree into the field of chiropractic science. OAG 1-01.

448.51 License required.

(1) Except as provided in s. 448.52, no person may practice physical therapy unless the person is licensed as a physical therapist under this subchapter or holds a valid physical therapist compact privilege.

(1e) No person may designate himself or herself as a physical therapist or use or assume the title "physical therapist," "physiotherapist," "physical therapy technician," "licensed physical therapist," "registered physical therapist," "master of physical therapy," "master of science in physical therapy," or "doctorate in physical therapy," or append to the person's name the letters "P.T.," "P.T.T.," "L.P.T.," "R.P.T.," "M.P.T.," "M.S.P.T.," or "D.P.T.," or any other title, letters, or designation that represents or may tend to represent the person as a physical therapist, unless the person is licensed as a physical therapist under this subchapter or holds a valid physical therapist compact privilege.

(1s) No person may designate himself or herself as a physical therapist assistant, use or assume the title "physical therapist assistant," or append to the person's name the letters "P.T.A." or any other title, letters, or designation that represents or may tend to represent the person as a physical therapist assistant unless the person is licensed as a physical therapist assistant under this subchapter or holds a valid physical therapist assistant compact privilege.

(2) Except as provided in s. 448.52 (2m), no person may claim to render physical therapy or physiotherapy services unless the person is licensed as a physical therapist under this subchapter or holds a valid physical therapist compact privilege.

448.52 Applicability.

(1m) A license is not required under this subchapter for any of the following, if the person does not claim to render physical therapy or physiotherapy services:

- (a) Any person lawfully practicing within the scope of a license, permit, registration or certification granted by this state or the federal government.
- (b) Any person assisting a physical therapist in practice under the direct, on-premises supervision of the physical therapist.
- (c) A physical therapy student assisting a physical therapist in the practice of physical therapy or a physical therapist assistant student assisting a physical therapist in performing physical therapy procedures and related tasks, if the assistance is within the scope of the student's education or training.
- (d) A physical therapist who is licensed to practice physical therapy in another

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state or country and is providing a consultation or demonstration with a physical therapist who is licensed under this subchapter.

- (2m)** A license is not required under this subchapter for any of the following:
- (a) Except as provided in par. (b), a chiropractor licensed under ch. 446 claiming to render physical therapy, if the physical therapy is provided by a physical therapist employed by the chiropractor.
 - (b) A chiropractor licensed under ch. 446 claiming to render physical therapy modality services.

448.522 Manipulation services. A physical therapist may not claim that any manipulation service that he or she provides is in any manner a chiropractic adjustment that is employed to correct a spinal subluxation.

448.527 Code of ethics. The examining board shall promulgate rules establishing a code of ethics governing the professional conduct of physical therapists and physical therapist assistants.

448.53 Licensure of physical therapists.

- (1)** The examining board shall grant a license as a physical therapist to a person who does all of the following:
- (a) Submits an application for the license to the department on a form provided by the department.
 - (b) Pays the fee specified in s. 440.05 (1)
 - (c) Submits evidence satisfactory to the examining board that the applicant does not have an arrest or conviction record.
 - (d) Submits evidence satisfactory to the examining board that the applicant is a graduate of a school of physical therapy approved by the affiliated credentialing board, unless the affiliated credentialing board waives this requirement under sub. (3).
 - (e) Passes an examination under s. 448.54
 - (f) If the person was educated at a physical therapy school that is not in the United States, the person satisfies any additional requirements for demonstrating competence to practice physical therapy that the examining board may establish by rule.

448.535 Licensure of physical therapist assistants.

- (1)** The examining board shall grant a license as a physical therapist assistant to a person who does all of the following:
- (a) Submits an application for the license to the department on a form provided by the department.
 - (b) Pays the fee specified in s. 440.05 (1).
 - (c) Submits evidence satisfactory to the examining board that the applicant does not have an arrest or conviction record.
 - (d) Submits evidence satisfactory to the examining board that the applicant is a graduate of a physical therapist assistant educational program accredited by an

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agency that is approved by the affiliated credentialing board.

(e) Passes an examination under s. 448.54.

(2) The examining board may waive a requirement under sub. (1) (d) or (e), or both, for an applicant who establishes to the satisfaction of the affiliated credentialing board that he or she is licensed as a physical therapist assistant by another licensing jurisdiction in the United States. The examining board shall promulgate rules for granting a waiver under this subsection. The rules may require an applicant to satisfy additional requirements as a condition for granting a waiver.

448.54 Examination.

(1) The examining board shall conduct or arrange for examinations for physical therapist and physical therapist assistant licensure at least semiannually and at times and places determined by the examining board.

(2)(a) Except as provided in sub. (3) examinations for physical therapist licensure shall consist of written or oral tests, or both, requiring applicants to demonstrate minimum competency in subjects substantially related to the practice of physical therapy.

(b) Examinations for physical therapist assistant licensure shall consist of written or oral tests, or both, requiring applicants to demonstrate minimum competency in the technical application of physical therapy services.

(3) Notwithstanding s. 448.53 (1) (f), the examining board may not require an applicant for physical therapist licensure to take an oral examination or an examination to test proficiency in the English language for the sole reason that the applicant was educated at a physical therapy school that is not in the United States if the applicant establishes, to the satisfaction of the examining board, that he or she satisfies the requirements under s. 448.53 (3).

448.55 Issuance of license; expiration and renewal.

(1) The department shall issue a certificate of licensure to each person who is licensed under this subchapter.

(2) The renewal dates for licenses granted under this subchapter, other than temporary licenses granted under rules promulgated under s. 448.53 (2), are specified under s. 440.08 (2) (a). Renewal applications shall be submitted to the department on a form provided by the department and shall include the renewal fee specified in s. 440.08 (2) (a) and proof of compliance with the requirements established in any rules promulgated under sub. (3).

(3) The examining board shall promulgate rules that require an applicant for renewal of a license to demonstrate continued competence as a physical therapist or physical therapist assistant.

448.56 Practice requirements.

(1) Written referral.

Except as provided in this subsection and s. 448.52, a person may practice physical therapy only upon the written referral of a physician, physician assistant, chiropractor, dentist, podiatrist, or advanced practice nurse prescriber certified under s. 441.16 (2). Written referral is not required if a physical therapist provides services in schools to children with disabilities, as defined in s. 115.76 (5), pursuant to rules promulgated by the department of public instruction; provides services as part of a home health care agency; provides services to a patient in a nursing home pursuant to the patient's plan of care; provides services related to athletic activities, conditioning, or injury prevention; or provides services to an individual for a previously diagnosed medical condition after informing the individual's physician, physician assistant, chiropractor, dentist, podiatrist, or advanced practice nurse prescriber certified under s. 441.16 (2) who made the diagnosis. The examining board may promulgate rules establishing additional services that are excepted from the written referral requirements of this subsection.

(1m)(a) Duty to refer.

(a) A physical therapist shall refer a patient to an appropriate health care practitioner if the physical therapist has reasonable cause to believe that symptoms or conditions are present that require services beyond the scope of the practice of physical therapy.

(b) The examining board shall promulgate rules establishing the requirements that a physical therapist must satisfy if a physician, chiropractor, dentist, or podiatrist makes a written referral under sub. (1). The purpose of the rules shall be to ensure continuity of care between the physical therapist and the health care practitioner.

(2) Fee splitting. No licensee may give or receive, directly or indirectly, to or from any other person any fee, commission, rebate or other form of compensation or anything of value for sending, referring or otherwise inducing a person to communicate with a licensee in a professional capacity, or for any professional services not actually rendered personally by the licensee or at the licensee's direction.

(3) Billing by professional partnerships and corporations. If 2 or more physical therapists have entered into a bona fide partnership or have formed a service corporation for the practice of physical therapy, the partnership or corporation may not render a single bill for physical therapy services provided in the name of the partnership or corporation unless each physical therapist who provided services that are identified on the bill is identified on the bill as having rendered those services.

(4) Responsibility. A physical therapist is responsible for managing all aspects of the physical therapy care of each patient under his or her care.

(5) Patient records. A physical therapist shall create and maintain a patient record for every patient the physical therapist examines or treats.

(6) Physical therapist assistants. A physical therapist assistant may assist a physical therapist in the practice of physical therapy if the physical therapist provides direct or general supervision of the physical therapist assistant. The affiliated credentialing board shall promulgate rules defining “direct or general supervision” for purposes of this subsection. Nothing in this subsection interferes with delegation authority under any other provision of this chapter.

(7) Ordering X-rays

(a) A physical therapist may order X-rays to be performed by qualified persons only if the physical therapist satisfies one of the following qualifications, as further specified by the examining board by rule:

1. The physical therapist holds a clinical doctorate degree in physical therapy.
2. The physical therapist has completed a nationally recognized specialty certification program.
3. The physical therapist has completed a nationally recognized residency or fellowship certified by an organization recognized by the examining board.
4. The physical therapist has completed a formal X-ray ordering training program with demonstrated physician involvement.

(b) When a physical therapist orders an X-ray, the physical therapist shall communicate with the patient's primary care physician or an appropriate health care practitioner to ensure coordination of care, unless all of the following apply:

1. A radiologist has read the X-ray and not identified a significant finding.
2. The patient does not have a primary care physician.
3. The patient was not referred to the physical therapist by another health care practitioner to receive care from the physical therapist.

448.565 Complaints. The affiliated credentialing board shall promulgate rules establishing procedures and requirements for filing complaints against licensees and shall publicize the procedures and requirements.

448.567 Performance audits. The examining board shall promulgate rules that require the examining board on a periodic basis to conduct performance self-audits of its activities under this subchapter.

448.57 Disciplinary proceedings and actions.

(1) Subject to the rules promulgated under s. 440.03 (1), the examining board may make investigations and conduct hearings to determine whether a violation of this subchapter or any rule promulgated under this subchapter has occurred.

(2) Subject to the rules promulgated under s. 440.03 (1), the examining board may reprimand a licensee or may deny, limit, suspend or revoke a license

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granted under this subchapter if it finds that the applicant or licensee has done any of the following:

- (a) Made a material misstatement in an application for a license or for renewal of a license.
- (am) Interfered with an investigation or disciplinary proceeding by using threats, harassment, or intentional misrepresentation of facts.
- (b) Been convicted of an offense the circumstances of which substantially relate to the practice of physical therapy or assisting in the practice of physical therapy.
- (bm) Been adjudicated mentally incompetent by a court.
- (c) Advertised in a manner that is false, deceptive or misleading.
- (d) Advertised, practiced or attempted to practice under another's name.
- (e) Practiced or assisted in the practice of physical therapy while the applicant's or licensee's ability to practice or assist was impaired by alcohol or other drugs.
- (f) Engaged in unprofessional or unethical conduct in violation of the code of ethics established in the rules.
- (fm) Engaged in sexual misconduct with a patient.
- (g) Engaged in conduct while practicing or assisting in the practice of physical therapy which evidences a lack of knowledge or ability to apply professional principles or skills.
- (h) Violated this subchapter or any rule promulgated under this subchapter.

(3)(a) A licensee may voluntarily surrender his or her license to the examining board, which may refuse to accept the surrender if the affiliated credentialing board has received allegations of unprofessional conduct against the licensee. The examining board may negotiate stipulations in consideration for accepting the surrender of licenses.

(b) The examining board may restore a license that has been voluntarily surrendered under par. (a) on such terms and conditions as it considers appropriate.

(4) The examining board shall prepare and disseminate to the public an annual report that describes final disciplinary action taken against licensees and compact privilege holders during the preceding year.

(5) The examining board may report final disciplinary action taken against a licensee or compact privilege holder to any national database that includes information about disciplinary action taken against health care professionals.

448.58 Injunctive relief. If the affiliated credentialing board has reason to believe that any person is violating this subchapter or any rule promulgated under this subchapter, the examining board, the department, the attorney general or the district attorney of the proper county may investigate and may, in addition to any other remedies, bring an action in the name and on behalf of this state to enjoin the person from the violation.

448.59 Penalties. Any person who violates this subchapter or any rule

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promulgated under this subchapter may be fined not more than \$10,000 or imprisoned for not more than 9 months or both.

Wisconsin Statutes, Chapter 146 - Abridged (Miscellaneous Health Provisions)

To read the statutes in their entirety, please go to: <https://docs.legis.wisconsin.gov/statutes/statutes/146>

146.81 Health care records; definitions

(2) "Informed consent" means written consent to the disclosure of information from patient health care records to an individual, agency or organization that includes all of the following:

- (a) The name of the patient whose record is being disclosed.
- (b) The type of information to be disclosed.
- (c) The types of health care providers making the disclosure.
- (d) The purpose of the disclosure such as whether the disclosure is for further medical care, for an application for insurance, to obtain payment of an insurance claim, for a disability determination, for a vocational rehabilitation evaluation, for a legal investigation or for other specified purposes.
- (e) The individual, agency or organization to which disclosure may be made.
- (f) The signature of the patient or the person authorized by the patient and, if signed by a person authorized by the patient, the relationship of that person to the patient or the authority of the person.
- (g) The date on which the consent is signed.
- (h) The time period during which the consent is effective.

(3) "Patient" means a person who receives health care services from a health care provider.

(4) "Patient health care records" means all records related to the health of a patient prepared by or under the supervision of a health care provider; "Patient health care records" includes billing statements and invoices for treatment or services provided by a health care provider and includes health summary forms.

(5) "Person authorized by the patient" means the parent, guardian, or legal custodian of a minor patient, the person vested with supervision of the child, the guardian of a patient adjudicated incompetent in this state, the personal representative, spouse, or domestic partner of a deceased patient, any person authorized in writing by the patient or a health care agent designated by the patient if the patient has been found to be incapacitated, except as limited by the power of attorney for health care instrument. If no spouse or domestic partner survives a deceased patient, "person authorized by the patient" also means an adult member of the deceased patient's immediate family. A court may appoint a temporary guardian for a patient believed incompetent to consent to the release of records under this section as the person authorized by the patient to decide upon the release of records, if no guardian has been appointed for the patient.

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146.819 Preservation or destruction of patient health care records.

(1) Any health care provider who ceases practice or business as a health care provider or the personal representative of a deceased health care provider who was an independent practitioner shall do one of the following for all patient health care records in the possession of the health care provider when the health care provider ceased business or practice or died:

(a) Provide for the maintenance of the patient health care records by a person who states, in writing, that the records will be maintained in compliance with ss. 146.81 to 146.835.

(b) Provide for the deletion or destruction of the patient health care records.

(2) If the healthcare provider or personal representative provides for the maintenance of any of the patient health care records under sub. (1), the health care provider or personal representative shall also do at least one of the following:

(a) Provide written notice, by 1st class mail, to each patient or person authorized by the patient whose records will be maintained, at the last-known address of the patient or person, describing where and by whom the records shall be maintained.

(b) Publish a class 3 notice in a newspaper that is published in the county in which the health care provider's or decedent's health care practice was located, specifying where and by whom the patient health care records shall be maintained.

(3) If the health care provider or personal representative provides for the deletion or destruction of any of the patient health care records, the health care provider or personal representative shall also do at least one of the following:

(a) Provide notice to each patient or person authorized by the patient whose records will be deleted or destroyed, that the records pertaining to the patient will be deleted or destroyed. The notice shall be provided at least 35 days prior to deleting or destroying the records, shall be in writing and shall be sent, by 1st class mail, to the last-known address of the patient to whom the records pertain or the last-known address of the person authorized by the patient. The notice shall inform the patient or person authorized by the patient of the date on which the records will be deleted or destroyed, unless the patient or person retrieves them before that date, and the location where, and the dates and times when, the records may be retrieved by the patient or person.

(b) Publish a class 3 notice in a newspaper that is published in the county in which the health care provider's or decedent's health care practice was located, specifying the date on which the records will be deleted or destroyed, unless the patient or person authorized by the patient retrieves them before that date, and the location where, and the dates and times when, the records may be retrieved by the patient or person.

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(4) This section does not apply to a health care provider that is any of the following:

- (a) A community-based residential facility or nursing home licensed under s. 50.03.
- (b) A hospital approved under s. 50.35.
- (c) A hospice licensed under s. 50.92.
- (d) A home health agency licensed under s. 50.49 (4).
- (f) A local health department, as defined in s. 250.01 (4), that ceases practice or business and transfers the patient health care records in its possession to a successor local health department.

146.82 Confidentiality of patient health care records.

(1) Confidentiality. All patient health care records shall remain confidential. Patient health care records may be released only to the persons designated in this section or to other persons with the informed consent of the patient or of a person authorized by the patient.

(2) Access without informed consent.

- (a) patient health care records shall be released upon request without informed consent in the following circumstances:
1. To health care facility staff committees, or accreditation or health care services review organizations for the purposes of conducting management audits, financial audits, program monitoring and evaluation, health care services reviews or accreditation.
 2. To the extent that performance of their duties requires access to the records, to a health care provider or any person acting under the supervision of a health care provider or to a person licensed under s. 256.15, including medical staff members, employees or persons serving in training programs or participating in volunteer programs and affiliated with the health care provider, if any of the following is applicable:
 - a. The person is rendering assistance to the patient.
 - b. The person is being consulted regarding the health of the patient.
 - c. The life or health of the patient appears to be in danger and the information contained in the patient health care records may aid the person in rendering assistance.
 - d. The person prepares or stores records, for the purposes of the preparation or storage of those records.
 3. To the extent that the records are needed for billing, collection or payment of claims.
 4. Under a lawful order of a court of record.
 5. In response to a written request by any federal or state governmental agency to perform a legally authorized function, including but not limited to management

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audits, financial audits, program monitoring and evaluation, facility licensure or certification or individual licensure or certification. The private pay patient, except if a resident of a nursing home, may deny access granted under this subdivision by annually submitting to a health care provider, other than a nursing home, a signed, written request on a form provided by the department. The provider, if a hospital, shall submit a copy of the signed form to the patient's physician.

6. For purposes of research if the researcher is affiliated with the health care provider and provides written assurances to the custodian of the patient health care records that the information will be used only for the purposes for which it is provided to the researcher, the information will not be released to a person not connected with the study, and the final product of the research will not reveal information that may serve to identify the patient whose records are being released under this paragraph without the informed consent of the patient. The private pay patient may deny access granted under this subdivision by annually submitting to the health care provider a signed, written request on a form provided by the department.

7. To an elder-adult-at-risk agency or other investigating agency for purposes of s. 46.90 (4) and (5) or to an adult-at-risk agency for purposes of s. 55.043. The health care provider may release information by initiating contact with the elder-adult-at-risk agency or adult-at-risk agency without receiving a request for release of the information from the elder-adult-at-risk agency or adult-at-risk agency.

(4) Release of a portion of a record to certain persons.

(b) a health care provider may release a portion, but not a copy, of a patient health care record, to the following, under the following circumstances:

1. Any person, if the patient or a person authorized by the patient is not incapacitated, is physically available, and agrees to the release of that portion.
2. Any of the following, as applicable, if the patient and person authorized by the patient are incapacitated or are not physically available, or if an emergency makes it impracticable to obtain an agreement from the patient or from the person authorized by the patient, and if the health care provider determines, in the exercise of his or her professional judgment, that release of a portion of the patient health care record is in the best interest of the patient:

- a. A member of the patient's immediate family, another relative of the patient, a close personal friend of the patient, or an individual identified by the patient, that portion that is directly relevant to the involvement by the member, relative, friend, or individual in the patient's care.

- b. Any person, that portion that is necessary to identify, locate, or notify a member of the patient's immediate family or another person that is responsible for the care of the patient concerning the patient's location, general condition, or death.

146.83 Access to patient health care records.

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(3) The health care provider shall note the time and date of each request by a patient or person authorized by the patient to inspect the patient's health care records, the name of the inspecting person, the time and date of inspection and identify the records released for inspection.

(4) No person may do any of the following:

(a) Intentionally falsify a patient health care record.

(b) Conceal or withhold a patient health care record with intent to prevent or obstruct an investigation or prosecution or with intent to prevent its release to the patient, to his or her guardian, to his or her health care provider with a statement of informed consent, or under the conditions specified in s. 146.82 (2), or to a person with a statement of informed consent.

(c) Intentionally destroy or damage records in order to prevent or obstruct an investigation or prosecution.

146.905(1) Reduction in fees prohibited

(1) Except as provided in sub. (2), a health care provider that provides a service or a product to an individual with coverage under a disability insurance policy may not reduce or eliminate or offer to reduce or eliminate coinsurance or a deductible required under the terms of the disability insurance policy.

(2) Subsection (1) does not apply if payment of the total fee would impose an undue financial hardship on the individual receiving the service or product.

Wisconsin Administrative Code Board of Physical Therapy Rules

To read the Wisconsin Physical Therapy Examining Board's Rules unabridged and in their entirety, please go to:
<https://dsps.wi.gov/Pages/RulesStatutes/PT.aspx>

Chapter PT 1 – License to Practice Physical Therapy

PT 1.01 Authority and purpose.

The rules in Chapters PT 1 to 9 are adopted by the physical therapy examining board and govern the issuance of licenses to physical therapists, the issuance of licenses to physical therapist assistants.

PT 1.02 Definitions.

(1) "Board" means the physical therapy examining board.

(3) "Client" means a person who has contracted for, who receives, and or who has previously received or contracted for, the professional services of a physical therapist, a physical therapist assistant, student or temporary licensee, whether the physical therapist, student or temporary licensee is paid or unpaid for the service, and regardless of where such services occur. If a client is a person under age 18, the client's parent or legal guardian are also clients.

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(4) “Direct, immediate, on–premises supervision” means face–to–face contact between the supervisor and the person being supervised, as necessary, with the supervisor physically present in the same building when the service is performed by the person being supervised.

(5) “Direct, immediate, one–to–one supervision” means one– to–one supervision with face–to–face contact between the person being supervised and the supervisor. The supervisor may assist the person being supervised as necessary.

(6) “FSBPT” means the Federation of State Boards of Physical Therapy.

(7) “General supervision” means direct, on–premises contact between a supervisor, and a physical therapist, physical therapist assistant, student or temporary licensee being supervised, as necessary. Between direct contacts, a supervisor is required to maintain indirect, off–premises telecommunication contact such that the person being supervised can, within 24 hours, establish direct telecommunication with a supervisor.

(8) “Informed consent” means a client’s voluntary, knowing and understood agreement to the service to be provided by the physical therapist, physical therapist assistant, temporary licensee, candidate for reentry, or student. Informed consent requires, at a minimum, that the licensee has provided information about reasonable alternate modes of diagnosis and treatment, and the risks and benefits of each, that a reasonable person in the client’s position would need before making an informed decision concerning the mode of treatment or diagnosis.

(a) Informed consent may ordinarily be documented by the written signature of the client, the client’s guardian or the client’s power of attorney for healthcare, or in the alternative by a notation in the patient’s health care record as defined in s. 146.81 (4), Stats. If circumstances prevent signed documentation by the client, the licensee may document verbal consent within the patient’s health care record.

(b) A client may withdraw informed consent verbally or in writing at any time before a service is completed.

(c) Informed consent shall include an understanding that the client may, upon request, have a chaperone present while services are provided.

(d) No service or part of a service may be provided without the client’s informed consent or after informed consent has been withdrawn

(e) No service or part of a service may be provided without informing the client of the general nature of the costs associated with the service provided or contact information for the entity who can address billing concerns

(12) “Supervisor” means a person holding a regular license as a physical therapist who is competent to coordinate, direct, and inspect the

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accomplishments of another physical therapist, physical therapist assistant, student, or temporary licensee.

(14) “Unlicensed personnel” means a person other than a physical therapist or physical therapist assistant who performs patient related tasks consistent with the unlicensed personnel’s education, training and expertise under the direct on-premises supervision of the physical therapist.

PT 1.03 Licensure Requirements.

(1) Every person applying for any class of license to provide physical therapy services shall make application on forms provided by the board, and shall submit to the board all of the following:

(a) A completed and verified application form.

(c) Verified documentary evidence of graduation from a school of physical therapy or a physical therapist assistant educational program approved by the board.

(d) In the case of a graduate of a foreign school of physical therapy or physical therapist assistant educational program, verification of educational equivalency to a board-approved school of physical therapy or physical therapist assistant educational program, the verification shall be obtained from a board-approved foreign graduate evaluation service, based upon submission to the evaluation service of the following material:

1. A verified copy of transcripts from the schools from which secondary education was obtained.
2. A verified copy of the diploma from the school or educational program at which professional physical therapy or physical therapist assistant training was completed.
3. A record of the number of class hours spent in each subject, for both pre-professional and professional courses. For subjects which include laboratory and discussion sections, the hours must be described in hours per lecture, hours per laboratory and hours per discussion per week. Information must include whether subjects have been taken at basic entry or advanced levels.
4. A syllabus which describes the material covered in each subject completed.

(2) If an applicant is a graduate of a school of physical therapy or a physical therapist assistant educational program not approved by the board, the board shall determine whether the applicant's educational training is equivalent to that specified in sub. (1) (c). In lieu of its own evaluations, the board may use evaluations prepared by a board-approved evaluation service. The cost of an evaluation shall be paid by the applicant.

(3) The board may waive the requirement under sub. (1) (c). for an applicant who establishes, to the satisfaction of the board, all of the following:

(a) That he or she is a graduate of a physical therapy school or a physical therapist assistant educational program.

(b) That he or she is licensed as a physical therapist or physical therapist assistant by another licensing jurisdiction in the United States.

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(c) That the jurisdiction in which he or she is licensed required the licensee to be a graduate of a school or educational program approved by the licensing jurisdiction or of a school or educational program that the licensing jurisdiction evaluated for educational equivalency.

(d) That he or she has actively practiced as a physical therapist or physical therapist assistant, under the license issued by the other licensing jurisdiction in the United States, for at least 3 years immediately preceding the date of his or her application.

Chapter PT 2 - Examinations

PT 2.02 Conduct of examinations.

At the start of the examinations, applicants shall be provided with the rules of conduct to be followed during the course of the examinations. Any violation of these rules of conduct by any applicant may be cause for the board to withhold the applicant's grade and to find after a hearing that the applicant has failed the examination.

PT 2.03 Failure and reexamination.

An applicant who fails to achieve a passing grade on the examination on statutes and rules may retake the examination upon submission of a reexamination fee.

Chapter PT 3 – Temporary Licenses

PT 3.01 Temporary license to practice under supervision.

(1) An applicant for a regular license to practice as a physical therapist or physical therapist assistant who is a graduate of an approved school of physical therapy or a physical therapist assistant educational program and has applied to take the national physical therapist examination or the national physical therapist assistant examination or has taken the national physical therapist examination and is awaiting results and is not required to take an oral examination, may apply to the board for a temporary license to practice as a physical therapist or physical therapist assistant under supervision. The applications and required documents for a regular license and for a temporary license may be reviewed by 2 members of the board, and upon the finding by the 2 members that the applicant is qualified for admission to examination for a regular license to practice as a physical therapist or physical therapist assistant, the board, acting through the 2 members, may issue a temporary license to practice as a physical therapist or physical therapist assistant under supervision to the applicant.

(2) The required fees specified in s. 440.05 (6), Stats., shall accompany the application for a temporary license to practice under supervision.

(3) The holder of a temporary license to practice physical therapy under supervision may practice physical therapy as defined in s. 448.50 (4), Stats., providing that the entire practice is under the supervision of a person validly

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holding a regular license as a physical therapist. The supervision shall be direct, immediate, and on premises.

(4) The holder of a temporary license to practice as a physical therapist assistant under supervision may provide physical therapy services as defined in s. 448.50 (4), Stats., providing that the entire practice is under the supervision of a person validly holding a regular license as a physical therapist. The supervision shall be direct, immediate, and on premises. No physical therapist assistant holding a temporary license may provide physical therapy services when the supervising physical therapist is not immediately available to assist.

(5) The duration of a temporary license to practice physical therapy under supervision granted under this section shall be for a period of 3 months or until the holder receives failing examination results, whichever is shorter.

(6) A physical therapist may supervise no more than a combined total of 4 physical therapists and physical therapist assistants who hold temporary licenses. This number shall be reduced by the number of physical therapist assistants and physical therapy aides being supervised by the physical therapist under s. PT 5.02 (2) (k).

Chapter PT 4 – Locum Tenens License

PT 4.01 Locum tenens license.

(1) A person who holds a valid license to practice physical therapy issued by another licensing jurisdiction of the United States may apply to the board for a locum tenens license to practice physical therapy and shall submit to the board all of the following:

- (a) A completed and verified application form.
- (b) A letter of recommendation from a physician or supervisor or present employer stating the applicant's professional capabilities.
- (c) A verified photostatic copy of a license to practice physical therapy issued to the applicant by another licensing jurisdiction of the United States.
- (d) A letter from a physical therapist licensed in this state requesting the applicant's services, or a letter from an organization or facility in this state requesting the applicant's services.
- (e) The required fees specified in s. 440.05 (6), Stats.

(2) The application and documentary evidence submitted by the applicant shall be reviewed by a member of the board, and upon the finding of the member that the applicant is qualified, the board, acting through the member, may issue a locum tenens license to practice physical therapy to the applicant.

(3) The holder of a locum tenens license to practice physical therapy may practice physical therapy as defined in s. 448.56 (1), Stats., providing the practice is confined to the geographical area for which the license is issued.

(4) A locum tenens license to practice physical therapy shall expire 90 days from

the date of its issuance. For cause shown to its satisfaction, the board, acting through a member of the board, may renew the locum tenens license for additional periods of 90 days each, but the license may not be renewed within 12 months of the date of its original issuance, nor again renewed within 12 months of the date of any subsequent renewal.

Chapter PT 5 – Physical Therapist Assistants and Unlicensed Personnel

PT 5.01 Practice and supervision of physical therapist assistants.

(1) A physical therapist assistant, as defined in s. 448.50 (3m), Stats., shall assist a physical therapist in the practice of physical therapy under the general supervision of a physical therapist.

(2) In providing general supervision, the physical therapist shall do all of the following:

- (a) Have primary responsibility for physical therapy care rendered by the physical therapist assistant.
- (b) Have direct face-to-face contact with the physical therapist assistant at least every 14 calendar days, unless the board approves another type of contact.
- (c) Remain accessible to telecommunications in the interim between direct contacts while the physical therapist assistant is providing patient care.
- (d) Establish a written policy and procedure for written and oral communication. This policy and procedure shall include a specific description of the supervisory activities undertaken for the physical therapist assistant as well as a description of the manner by which the physical therapist shall manage all aspects of patient care. The amount of supervision shall be appropriate to the setting and the services provided.
- (e) Provide initial patient examination, evaluation and interpretation of referrals and create the initial patient record for every patient the physical therapist treats.
- (f) Develop and revise as appropriate a written patient treatment plan and program.
- (g) Delegate appropriate portions of the treatment plan and program to the physical therapist assistant consistent with the physical therapist assistant's education, training and experience.
- (h) Provide on-site assessment and reevaluation of each patient's treatment at a minimum of one time per calendar month or every tenth treatment day, whichever is sooner, and adjust the treatment plan as appropriate.
- (i) Coordinate discharge plan decisions and the final assessment with the physical therapist assistant.
- (j) Limit the number of physical therapist assistants practicing under general supervision to a number appropriate to the setting in which physical therapy is administered, to ensure that all patients under the care of the physical therapist receive services that are consistent with accepted standards of care and consistent with all other requirements under this chapter. No physical therapist may at any time supervise more than 2 physical therapist assistants full-time

equivalents practicing under general supervision.

PT 5.02 Supervision of unlicensed personnel.

(1) A physical therapist shall provide direct on-premises supervision of unlicensed personnel at all times. A physical therapist may not direct unlicensed personnel to perform tasks which require the decision making or problem solving skills of a physical therapist, including but not limited to patient examination, evaluation, diagnosis, or determination of therapeutic intervention.

(2) In providing direct on-premises supervision, the physical therapist shall do all of the following:

- (a) Retain full professional responsibility for patient related tasks performed.
- (b) Be available at all times for direction and supervision with the person performing related tasks.
- (c) Evaluate the effectiveness of patient related tasks performed by those under direct supervision by assessing persons for whom tasks have been performed prior to and following performance of the tasks.
- (d) Routinely evaluate the effectiveness of patient related tasks performed by those under direct supervision by observing and monitoring persons receiving such tasks.
- (e) Determine the competence of personnel to perform assigned tasks based upon his or her education, training and experience.
- (f) Verify the competence of unlicensed personnel with written documentation of continued competence in the assigned tasks.
- (g) Perform initial patient examination, evaluation, diagnosis and prognosis, interpret referrals, develop and revise as appropriate a written patient treatment plan and program for each patient and create and maintain a patient record for every patient the physical therapist treats.
- (h) Provide interpretation of objective tests, measurements and other data in developing and revising a physical therapy diagnosis, assessment and treatment plan.
- (i) Direct unlicensed personnel to provide appropriate patient related tasks consistent with the education, training, and experience of the person supervised. Direction should list specific patient related tasks, including dosage, magnitude, repetitions, settings, length of time, and any other parameters necessary for the performance of the patient related tasks.
- (j) Limit the number of unlicensed personnel providing patient related tasks under direct supervision to a number appropriate to the setting in which physical therapy is administered, to ensure that all patients under the care of the physical therapist receive services that are consistent with accepted standards of care and consistent with all other requirements under this chapter.
- (k) The total number of physical therapist assistants providing physical therapy services and unlicensed personnel performing patient related tasks under supervision may not exceed a combined total of 4. This number shall be reduced by the number of physical therapists and physical therapist assistants holding

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temporary licenses who are being supervised under s. PT 3.01 (6).

Chapter PT 6 - Referrals

PT 6.01 Referrals.

(1) In addition to the services excepted from written referral under s. 448.56, Stats., a written referral is not required to provide the following services, related to the work, home, leisure, recreational and educational environments:

- (a) Conditioning.
- (b) Injury prevention and application of biomechanics.
- (c) Treatment of musculoskeletal injuries with the exception of acute fractures or soft tissue avulsions.

(2) A physical therapist providing physical therapy services pursuant to a referral under s. 448.56 (1), Stats., shall communicate with the referring physician, chiropractor, dentist or podiatrist as necessary to ensure continuity of care.

(3) A physical therapist providing physical therapy services to a patient shall refer the patient to a physician, chiropractor, dentist, podiatrist or other health care practitioner under s. 448.56 (1m), Stats., to receive required health care services which are beyond the scope of practice of physical therapy.

Chapter PT 7 – Unprofessional Conduct

PT 7.01 Authority and intent. The definitions of this chapter are adopted by the board pursuant to the authority delegated by ss. 15.085 (5) (b) and 448.527, Stats., to establish the standards of ethical conduct by physical therapists and physical therapist assistants.

PT 7.025 Unprofessional Conduct. The term "unprofessional conduct" is defined to include violating, aiding, abetting, or conspiring to engage in any of the following:

(1) Violating s. 448.57 (2) (a) to (g), Stats., other provision of chs. 440 and 448, Stats., or any provision of a board order

(2) Any physical therapist committing any act that constitutes a violation of the "Code of Ethics," effective July 1, 2010, as approved by the American Physical Therapy Association and herein incorporated by reference.

(3) Any physical therapist assistant committing any act that constitutes a violation of the "Standards of Ethical Conduct," effective July 1, 2010, as approved by the American Physical Therapy Association and herein incorporated by reference.

(4) Engaging in fraud, deceit, or misrepresentation in applying for or procuring a

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license to practice physical therapy, in connection with applying for or procuring periodic renewal of a license, or in otherwise maintaining licensure.

(5) Failing to complete continuing competence requirements within the time period established by law

(6) Permitting or assisting any person to perform acts constituting the practice of physical therapy without sufficient qualifications, necessary credentials, adequate informed consent, or adequate supervision. The physical therapist is responsible for determining whether general, direct, or one-on-one supervision is necessary to protect the patient from unacceptable risk of harm. The physical therapist retains responsibility for delegated or supervised acts, unless the board determines that the delegate knowingly and willfully violated the supervisor's direction or instruction.

(7) Engaging in any act of fraud, deceit, or misrepresentation, including acts of omission, to the board or any person acting on the board's behalf, including Department of Safety and Professional Services personnel.

(8) Any practice or conduct that falls below the standard of minimal competence within the profession that results in unacceptable risk of harm to the patient, regardless of whether injury results

(9) Negligence in the practice of physical therapy, regardless of whether injury results.

(10) Practicing as a physical therapist or working as a physical therapist assistant when physical or mental abilities are impaired by the use of controlled substances or other habit-forming drugs, chemicals or alcohol, or by other causes.

(11) Practicing physical therapy with a mental or physical condition that impairs the ability of the licensee to practice within the standard of minimal competence or without exposing the patient to an unacceptable risk of harm

(12) Performing any act constituting the practice of physical therapy on any patient without the patient's informed consent or after the patient has withdrawn informed consent, whether verbally or in writing, or either of the following:

(a) Failure to document informed consent.

(b) Failure to inform the patient that any act of physical therapy may or will be performed by unlicensed personnel.

(13) Practicing beyond the scope of any professional credential issued by the board or any other state or federal agency

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(14) Knowingly, negligently, or recklessly making any statement, written or oral, in the course of the practice of physical therapy or as a physical therapist assistant, which is likely to deceive, defraud, mislead, or create an unacceptable risk of harm to the patient or the public or both.

(15)) Divulging a privileged communication or other confidential patient health care information except as required or permitted by state or federal law

(16) Engaging in sexually explicit conduct, sexual contact, exposure, gratification, or other sexual behavior with or in the presence of a patient, a patient's immediate family member, or a person responsible for the patient's welfare. For the purposes of this subsection all of the following may apply:

(a) Sexual motivation may be determined from the totality of the circumstances and is presumed when the physical therapist or physical therapist assistant has contact with a patient's intimate parts without legitimate professional justification for doing so.

(b) An adult receiving treatment shall continue to be a patient for 6 months after the termination of professional services.

(c) If the person receiving treatment is a minor, the person shall continue to be a patient for the purposes of this paragraph for 2 years after termination of services or for 2 years after the patient reaches the age of majority, whichever is longer.

(d) It is a violation of this paragraph for a physical therapist or physical therapist assistant to engage in any sexual contact or conduct with or in the presence of a patient or former patient who lacks the ability to consent for any reason, including age, medication, or psychological or cognitive disability.

(17) Illegal or unethical business practices, including either of the following:

(a) Fraud, deceit, or misrepresentation in obtaining or attempting to obtain any fee or third-party reimbursement.

(b) Engaging in uninvited, in-person solicitation of actual or potential patients who, because of their particular circumstances, are vulnerable to undue influence.

(18) Providing treatment intervention unwarranted by the condition of the patient or continuing treatment beyond the point of reasonable benefit.

(19) Violation or conviction of any federal or state law, including criminal law, which is therefore substantially related to the practice of physical therapy and which bars any of the following conduct:

(a) Theft or fraud.

(b) Violence.

(c) Sexual contact with a patient, patient's guardian or family member, or any act performed in the presence of a patient, patient's guardian or family member, for the purposes of sexual gratification.

(d) Victimization of children, elderly, or other vulnerable person.

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(e) Any crime occurring in the course of the practice of physical therapy by a physical therapist or a physical therapist assistant, or in any place in which physical therapy is practiced.

(f) Conclusive evidence of a violation of this subsection shall be a certified copy of any document demonstrating the entry of a guilty plea, nolo contendere plea, alford plea, or entrance into a deferred prosecution agreement, with or without being expunged, pertaining to a crime substantially related to the practice of physical therapy.

(20) Violation or conviction of any federal or state law or rule that is substantially related to the practice of physical therapy. For the purposes of this subsection the following may apply:

(a) Except as otherwise provided by law, a certified copy of a relevant decision by a state or federal court or agency charged with making legal determinations relevant to this paragraph is conclusive evidence of its findings of facts and conclusions of law.

(b) Under this paragraph, the department has the burden of proving that the act is substantially related to the practice of physical therapy.

(21) Failure to establish and maintain accurate and timely patient health care records as required by law and professional standards. Patient health care records are presumed to be untimely if not completed and signed within 60 days of the date of service.

(22) Failure to timely transfer patient health records to any person or practitioner authorized by law to procure the patient health care records. Failure to comply with any lawful request for patient health care records within 30 days of receipt of the request is presumed to be a violation of this subsection.

(23) Having any credential pertaining to the practice of physical therapy result in adverse action by any agency of this or another state, or by any agency or authority within the federal government, which results in any disciplinary action, including limitation, restriction, suspension, revocation, or any other disciplinary action. This paragraph applies whether the adverse action results in temporary or permanent limitation, restriction, suspension, revocation, or disciplinary action. This paragraph applies whether or not the adverse action is accompanied by findings of negligence or unprofessional conduct.

(24) Failure, within 30 days, to report to the board any adverse action, whether final or temporary, taken against the licensee's authority to practice physical therapy as follows:

(a) Any adverse action by another licensing or credentialing jurisdiction concerned with the practice of physical therapy.

(b) Any adverse action by any division of the state or federal government that results in limitation or loss of authority to perform any act constituting the practice of physical therapy or as a physical therapist assistant.

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(25) Failure, within 30 days, to report to the board any voluntary agreement to limit, restrict, or relinquish the practice of physical therapy or as a physical therapist assistant entered into with any court or agency of any state or federal government.

(26) Failure to report to the board any incident in which the licensee has direct knowledge of reasonable cause to suspect that a physical therapist or physical therapist assistant has committed any unprofessional, incompetent, or illegal act in violation of state or federal statute, administrative rule, or orders of the board. Reports shall be made within the time necessary to protect patients from further unacceptable risk of harm, but no more than 30 days after the required reporter obtained knowledge of the act.

Chapter PT 8 – Biennial License Renewal

PT 8.02 Renewal required; method of renewal. Each licensee shall renew his or her license biennially with the department. Each licensee shall complete a renewal application form and return it with the required fee to the department prior to the next succeeding March 1.

PT 8.05 Requirements for reinstatement. A license shall expire if it is not renewed by March 1 of each odd-numbered year, except for temporary licenses granted pursuant to ch. PT 3. A licensee who allows their license to expire may apply to the board to renew or reinstate their license by completing one of the following:

(1) Renewal before 5 years. If the licensee applies for renewal of the license less than 5 years after its expiration, the license shall be renewed upon payment of the renewal fee and completion of the continuing education requirements specified in ch. PT 9.

(2) Renewal after 5 years or more. If the licensee applies for renewal of the license more than 5 years after its expiration, the board shall make inquiry as it finds necessary to determine whether the applicant is competent to practice under the license in this state, and shall impose any reasonable conditions on renewal of the license, including oral examination, as the board deems appropriate. All applicants under this paragraph shall be required to pass the open book examination on statutes and rules, which is the same examination given to initial applicants. This section does not apply to licensees who have unmet disciplinary requirements or whose licenses have been surrendered or revoked.

(3) Reinstatement. A licensee who has unmet disciplinary requirements and failed to renew within 5 years of the renewal date or whose license has been

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surrendered or revoked, may apply to have the license reinstated in accordance with all of the following:

- (a) Evidence of the completion of the requirements under s. PT 8.05 (2).
- (b) Evidence of completion of disciplinary requirements, if applicable.
- (c) Evidence of rehabilitation or change in circumstances warranting reinstatement of the license.

Chapter PT 9 – Continuing Education

PT 9.01 Authority and purpose. The rules in this chapter are adopted by the board pursuant to the authority delegated by ss. 15.085 (5) (b), 227.11 (2) and 448.55 (3), Stats., and govern required biennial continuing education of licensees of the board.

PT 9.02 Definitions.

- (1) "Contact hour" means not less than 50 minutes a licensee spends in actual attendance at or completion of acceptable continuing education.
- (2) "Continuing education" means planned, organized learning activities designed to maintain, improve, or expand a licensee's knowledge and skills relevant to the enhancement of practice, education, or theory development to improve the safety and welfare of the public.
- (4) "Licensee" means a person licensed to practice as a physical therapist or physical therapist assistant in this state.

PT 9.03 Continuing Education Requirements.

- (1) Unless granted a postponement or waiver under sub. (8), every physical therapist shall complete at least 30 hours of board-approved continuing education in each biennial registration period, as specified in s. 448.55 (3), Stats. Four of the required 30 hours shall be in the area of ethics, jurisprudence, or both.
- (2) Unless granted a postponement or waiver under sub. (8), every physical therapist assistant shall complete at least 20 hours of board-approved continuing education in each biennial registration period, as specified in s. 448.55 (3), Stats. Four of the required 20 hours shall be in the area of ethics, jurisprudence, or both.
- (3) Continuing education hours may apply only to the registration period in which the hours are acquired. If a license has lapsed, the board may grant permission to apply continuing education hours acquired after lapse of the license to a previous biennial period of licensure during which required continuing education was not acquired. In no case may continuing education hours be applied to more than one biennial period.

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(4) Unless granted a postponement or waiver under sub. (8), a licensee who fails to meet the continuing education requirements by the renewal deadline shall cease and desist from practice.

(5) During the time between initial licensure and commencement of a full 2-year licensure period new licensees shall not be required to meet continuing education requirements.

(6) Applicants from other states applying for a license to practice as a physical therapist under s. 448.53 (3), Stats., shall submit proof of completion of at least 30 hours of continuing education approved by the board within 2 years prior to application.

(7) Applicants from other states applying for a license to practice as a physical therapist assistant under s. 448.53 (3), Stats., shall submit proof of completion of at least 20 hours of continuing education approved by the board within 2 years prior to application.

(8) A licensee may apply to the board for a postponement or waiver of the requirements of this section on grounds of prolonged illness or disability, or on other grounds constituting extreme hardship. The board shall consider each application individually on its merits, and the board may grant a postponement, partial waiver or total waiver as deemed appropriate.

PT 9.04 Standards for Approval.

(1) To be approved for credit, a continuing education program shall meet all of the following criteria:

- (a) The program constitutes an organized program of learning that contributes directly to the licensee's knowledge, skill, behavior, and abilities related to the practice of physical therapy.
- (b) The program pertains to subject matters which integrally relate to the practice of the profession.
- (c) The program is conducted by individuals who have specialized education, training or experience by reason of which the individuals should be considered qualified concerning the subject matter of the activity or program.
- (d) The program fulfills pre-established goals and objectives.
- (e) The program provides proof of attendance by licensees.

(2) An activity described in Table PT 9.04 may qualify for continuing education hours. To be approved for credit, the activity shall integrally relate to the practice of the profession.

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Table PT 9.04

TABLE PT 9.04	
ACTIVITY	CONTACT HOUR LIMITS
(a) Successful completion of relevant academic coursework.	No limit. One semester credit equals 10 contact hours, and one quarter credit equals 6.6 contact hours.
(b) Attendance at seminars, workshops, lectures, symposia, and professional conferences which are sponsored or approved by acceptable health-related or other organizations including the American Physical Therapy Association and the Wisconsin Physical Therapy Association.	No limit.
(c) Successful completion of a self-study course or courses offered via electronic or other means which are sponsored or approved by acceptable health-related or other organizations including the American Physical Therapy Association and the Wisconsin Physical Therapy Association.	No limit.
(d) Earning a clinical specialization from the American Board of Physical Therapy Specialties or other recognized clinical specialization certifying organizations.	Up to 12 contact hours for initial certification or for recertification.
(e) Authorship of a book about physical therapy or a related professional area.	Up to 12 contact hours for each book.
(f) Authorship of one or more chapters of a book about physical therapy or a related professional area.	Up to 6 contact hours for each chapter.
(g) Authorship of a presented scientific poster, scientific platform presentation, or published article.	Up to 6 contact hours for each poster, platform presentation, or refereed article.
(h) Presenting seminars, continuing education courses, workshops, lectures, or symposia which have been approved by recognized health-related organizations including the American Physical Therapy Association and the Wisconsin Physical Therapy Association.	No limit for the initial presentation. No additional hours are given for subsequent presentations of the same content. Substantive course revisions may be counted, but are limited to the extent of the revision.
(i) Teaching in an academic course in physical therapy as a guest lecturer.	One semester credit equals 10 contact hours, and one quarter credit equals 6.6 contact hours. No additional hours are given for subsequent presentations of the same content. Substantive course revisions may be counted, but are limited to the extent of the revision.
(j) Teaching in an academic course in physical therapy.	One semester credit equals 10 contact hours, and one quarter credit equals 6.6 contact hours. No additional hours are given for subsequent presentations of the same content. Substantive course revisions may be counted, but are limited to the extent of the revision.
(k) Successful completion in a clinical residency program credentialed by the American Physical Therapy Association or other recognized credentialing organization.	No limit.
(L) Employer-provided continuing education.	Up to 15 contact hours for physical therapists. Up to 10 contact hours for physical therapist assistants.
(m) Authoring an article in a non-refereed publication.	Up to 5 contact hours.
(n) Developing alternative media materials, including computer software, programs, and video instructional material.	One contact hour per product. Up to 5 contact hours.
(o) Serving as a clinical instructor for internships with an accredited physical therapist or physical therapist assistant educational program.	Up to 15 contact hours for physical therapists. Up to 10 contact hours for physical therapist assistants.

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(p) Serving as a supervisor for students fulfilling clinical observation requirements.	One contact hour per contact hour with students, up to 5 contact hours.
(q) Participating in a physical therapy study group of 2 or more physical therapists or physical therapist assistants or in an interdisciplinary study group of members of at least 2 disciplines meeting on a topic relevant to the participants' work.	Up to 2 contact hours per study group.
(r) Participating as a resident or as a mentor in a formal nonacademic mentorship.	One contact hour per each 8 contact hours for both the resident and mentor, up to 5 contact hours.
(s) Attending a scientific poster session, lecture panel, or a symposium.	Up to 2 contact hours.
(t) Serving as a delegate to the American Physical Therapy Association House of Delegates or a member of a professional committee, board, or task force.	Up to 5 contact hours.

(3) None of the following activities qualify for continuing education hours:

- (a) Meetings for the purpose of policy decisions.
- (b) Non-educational meetings at annual association, chapter or organization meetings.
- (c) Entertainment or recreational meetings or activities.
- (d) Visiting exhibits.

PT 9.05 Certification and audit of continuing education requirements

Applicants for renewal shall certify completion of required continuing education hours. The board shall audit any licensee who is under investigation by the board for alleged misconduct.

Chapter 10 – Ordering X-rays

PT 10.02 Qualifications

A physical therapist may order x-rays to be performed by qualified persons if the physical therapist satisfies one of the following qualifications:

- (1) The physical therapist holds an entry level clinical doctorate or transitional clinical doctoral degree in physical therapy from a college or university that has a physical therapy program accredited by the Commission on Accreditation in Physical Therapy Education or a successor organization.
- (2) The physical therapist has been issued a specialty certification from the American Board of Physical Therapy Specialties. The clinical practice hours leading to the specialty certification shall include training in the practice of ordering x-rays. A specialty certification issued by a national organization other than the American Board of Physical Therapy Specialties satisfies the qualification under this subsection if the certification program meets the criteria under sub. (4) (a) to (f).
- (3) The physical therapist has completed a residency or fellowship accredited by the American Board of Physical Therapy Residency and Fellowship Education. The residency or fellowship shall include training in the practice of ordering x-rays. Completion of a residency or fellowship accredited by a national organization other than the American Board of Physical Therapy Residency and Fellowship Education satisfies the

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- qualification under this subsection if the residency or fellowship program meets the criteria under sub. (4) (a) to (f).
- (4) The physical therapist has successfully completed a formal x-ray ordering training program meeting all of the following criteria:
- (a) The program constitutes an organized program of learning which contributes directly to the professional competency of a licensee to order x-rays.
 - (b) The program pertains to subject matters which integrally relate to the practice of ordering x-rays.
 - (c) The program is conducted by individuals who have specialized education, training, or experience by reason of which the individuals should be considered qualified concerning the practice of ordering x-rays. This shall include demonstrated physician involvement in the development or presentation of the program.
 - (d) The program fulfills pre-established goals and objectives.
 - (e) The program provides proof of attendance by licensees.
 - (f) The program includes a final examination or other assessment of a licensees' competency to order x-rays.

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

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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

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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?

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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/sqft. (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

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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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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 therapy professionals; including those 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 and regulations 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

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6. What is the most important function of informed consent? (p. 18-21)
 - A. Protects health care providers against possible liability.
 - B. Provides each patient an opportunity to be an informed participant in their health care decisions.
 - C. Establishes an authoritative chain of command.
 - D. Safeguards against experimental treatments.

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 only on their ability to pay.
 - D. Provide pro bono services.

8. Gifts from companies to PT professionals are acceptable only when _____. (p. 23-24)
 - A. the primary purpose is the enhancement of patient care and medical knowledge
 - B. each professional in the field receives the same gift without regard to previous product usage
 - C. the company is introducing a new product or service to the market.
 - D. permission is received from the professional's employer

9. Which of the following is permitted under the Wisconsin PT statutes? (p. 30)
 - A. Provision of physical therapy services based upon the written referral of a dentist.
 - B. Provision of physical therapy treatment without a written referral in schools to children with disabilities.
 - C. Provision of physical therapy treatment without a written referral as part of a home health agency.
 - D. All of the above

10. Unlicensed physical therapy personnel are required to have _____. (p. 39)
 - A. Direct on-premise supervision by a physical therapist.
 - B. Indirect on-premise supervision by either a physical therapist or physical therapist assistant.
 - C. Line-of-sight supervision by either a physical therapist, physical therapist assistant, or a physician.
 - D. Continuous oversight by either a physical therapist, MD, DO, chiropractor, or podiatrist.

11. The Wisconsin PT Rules require what format and frequency of communication between a PT and a PTA under their supervision? (p. 42)
 - A. Telecommunication interaction at least every 7 days.
 - B. Direct face-to-face contact at least every 14 calendar days.
 - C. Written communication every 30 days.
 - D. As needed, determined by the supervising PT

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12. What is the maximum combined total of PTAs, temporary licensees and unlicensed personnel (performing patient related tasks) that may be supervised at one time by a PT? (p. 43)
- A. 2
 - B. 3
 - C. 4
 - D. 5
13. Which of the following is classified as “Unprofessional Conduct” under Chapter PT 7 of the WI Board of Physical Therapy Rules? (p. 44-48)
- A. Engaging in consensual sex with an adult patient two months after termination of professional services.
 - B. Failure to complete and sign patient health care records within 60 days of the date of service.
 - C. Failure to comply with any lawful request for patient records within 30 days of receipt of request.
 - D. All of the above.
14. Which of the following statements concerning Wisconsin physical therapy continuing education requirements is FALSE? (p. 49-52)
- A. Physical therapists must complete at least 30 hours of continuing education each biennial registration period.
 - B. Physical therapist assistants must complete at least 20 hours of continuing education each biennial registration period.
 - C. Licensees who complete continuing education hours in excess of their biennial requirement may apply (carry-over) the additional hours to their next licensure period.
 - D. As part of their total CE requirement, PTs & PTAs must complete four hours of Ethics, Jurisprudence, or both each biennial registration period.
15. It is unethical for a physical therapist to _____. (p. 56-57)
- 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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