Ethics & Jurisprudence – Utah Physical Therapy

Goals & Objectives

Course Description
"Ethics and Jurisprudence – Utah Physical Therapy" is an online continuing education course for Utah licensed physical therapists and physical therapist assistants. The course focuses on defining moral, ethical, and legal behavior of physical therapy professionals. The information presented includes the Utah Physical Therapy Practice Act (58-24b), the Utah Physical Therapy Practice Act Rules (R156-24b.), the APTA's Code of Ethics and Standards for Professional Conduct for Physical Therapist Assistants, model for ethical decision making, and hypothetical case analysis.

Course Rationale
This course is designed to educate, promote and facilitate ethical and legal behavior by Utah licensed physical therapist and physical therapist assistants. It is intended to fulfill the Ethics & Jurisprudence continuing education requirements of R156-24b-303b(1)(a)

Course Goals & Objectives
At the end of this course, the participants will be able to:

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

Course Provider – Innovative Educational Services

Course Instructor - Michael Niss, DPT

Target Audience – Utah licensed physical therapists and physical therapist assistants

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

Course Prerequisites – None

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

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

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

Ethics & Jurisprudence – Utah Physical Therapy

Outline

Ethics Overview

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

Ethics are important on several levels.

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

Ethics vs. Morals

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

Ethical Questions

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

Ethics Theories

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

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

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

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

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

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

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

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

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

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

Beneficence: the duty to do good.

Confidentiality: the duty to respect privacy of information.

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

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

Nonmaleficence: the duty to cause no harm.

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

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

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

Veracity: the duty to tell the truth.

Model for Ethical Decision Making

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

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

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

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

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

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

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

APTA Code of Ethics

Preamble

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

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

2. Provide standards of behavior and performance that form the basis of professional accountability to the public.

3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities.

4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.

5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

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

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

Principles

Principle #1:

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

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

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

Principle #2:

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

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

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

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

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

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

Principle #3:

Physical therapists shall be accountable for making sound professional judgments.

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

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

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

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

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

Principle #4:

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

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

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

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

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

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

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

Principle #5:

Physical therapists shall fulfill their legal and professional obligations.

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

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

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

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

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

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

Principle #6:

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

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

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

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

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

Principle #7:

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

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

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

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

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

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

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

Principle #8:

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

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

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

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

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

APTA's Guide for Professional Conduct

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Professional Growth
6D elaborates on the physical therapist's obligations to foster an environment conducive to professional growth, even when not supported by the organization. The essential idea

is that this is the physical therapist's responsibility, whether or not the employer provides support.

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

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

Standards of Ethical Conduct for the Physical Therapist Assistant

Standards

Standard #1:

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

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

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

Standard #2:

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

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

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

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

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

Standard #3:

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

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

3B. Physical therapist assistants shall be guided by information about best practice regarding physical therapy interventions.

3C. Physical therapist assistants shall make decisions based upon their level of competence and consistent with patient/client values.

3D. Physical therapist assistants shall not engage in conflicts of interest that interfere with making sound decisions.

3E. Physical therapist assistants shall provide physical therapy services under the direction and supervision of a physical therapist and shall communicate with the physical therapist when patient/client status requires modifications to the established plan of care.

Standard #4:

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

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

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

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

4D. Physical therapist assistants shall report suspected cases of abuse involving children or vulnerable adults to the supervising physical therapist and the appropriate authority, subject to law.

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

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

Standard #5:

Physical therapist assistants shall fulfill their legal and ethical obligations.

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

5B. Physical therapist assistants shall support the supervisory role of the physical therapist to ensure quality care and promote patient/client safety.

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

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

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

Standard #6:

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

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

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

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

Standard #7:

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

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

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

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

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

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

Standard #8:

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

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

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

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

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

APTA Guide for Conduct of the Physical Therapist Assistant

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

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

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

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

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

Informed Consent

Patients have a fundamental right to direct what happens to their bodies, grounded in the principles of autonomy and respect for persons. In turn, health care professionals have an ethical obligation to involve patients in a process of shared decision making and to seek patients' informed consent for treatments and procedures. Good informed consent practices, thus, are an essential

component of ethics quality in health care. And that means more than getting a patient's signature on a consent form.

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

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

Consent for Multiple Treatments

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

Blanket Consent

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

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

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

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

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

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

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

Resisting Treatment
Health care professionals face different concerns when patients who lack decision-making capacity resist treatment for which their authorized surrogates

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

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

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

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

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

Relationships

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

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

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

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

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

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

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

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

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

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

Gifts and Conflict of Interest

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

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

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

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

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

In recent years, many prominent organizations and associations have established ethical guidelines for health care professionals about accepting gifts from industry representatives. These guidelines do not prohibit all gifts from industry, but there is general agreement that gifts from companies to health care

professionals are acceptable only when the primary purpose is the enhancement of patient care and medical knowledge. The acceptance of individual gifts, hospitality, trips, and subsidies of all types from industry by an individual is strongly discouraged. Practitioners should not accept gifts, hospitality, services, and subsidies from industry if acceptance might diminish, or appear to others to diminish, the objectivity of professional judgment.

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

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

Confidentiality

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

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

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

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or

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

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

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

Utah Physical Therapy Practice Act (58-24b)

The following is an abridged version of the Utah Physical Therapy Practice Act 58-24b. To read the document in its entirety, please go to: http://le.utah.gov/xcode/Title58/Chapter24B/C58-24b_1800010118000101.pdf

Part 1 - General Provisions
58-24b-102. Definitions.
As used in this chapter:
(1) "Animal physical therapy" means practicing physical therapy or physiotherapy on an animal.
(3) "Consultation by telecommunication" means the provision of expert or professional advice by a physical therapist who is licensed outside of Utah to a licensed physical therapist or a health care provider by telecommunication or electronic communication.
(4) "General supervision" means supervision and oversight of a person by a licensed physical therapist when the licensed physical therapist is immediately available in person, by telephone, or by electronic communication to assist the person.
(8) "On-site supervision" means supervision and oversight of a person by a licensed physical therapist or a licensed physical therapist assistant when the licensed physical therapist or licensed physical therapist assistant is:
(a) continuously present at the facility where the person is providing services;
(b) immediately available to assist the person; and
(c) regularly involved in the services being provided by the person.
(9) "Physical impairment" means:
(a) a mechanical impairment;
(b) a physiological impairment;
(c) a developmental impairment;
(d) a functional limitation;
(e) a disability;
(f) a mobility impairment; or
(g) a bodily malfunction.
(10) (a) "Physical therapy" or "physiotherapy" means:
(i) examining, evaluating, and testing an individual who has a physical impairment or injury;

(ii) identifying or labeling a physical impairment or injury;
(iii) formulating a therapeutic intervention plan for the treatment of a physical impairment, injury, or pain;
(iv) assessing the ongoing effects of therapeutic intervention for the treatment of a physical impairment or injury;
(v) treating or alleviating a physical impairment by designing, modifying, or implementing a therapeutic intervention;
(vi) reducing the risk of an injury or physical impairment;
(vii) providing instruction on the use of physical measures, activities, or devices for preventative and therapeutic purposes;
(viii) promoting and maintaining health and fitness;
(ix) the administration of a prescription drug pursuant to Section 58-24b-403;
(x) subject to Subsection 58-28-307(12)(b), engaging in the functions described in Subsections (11)(a)(i) through (ix) in relation to an animal, in accordance with the requirements of Section 58-24b-405; and
(xi) engaging in administration, consultation, education, and research relating to the practices described in this Subsection (11)(a).

(b) "Physical therapy" or "physiotherapy" does not include:
(i) diagnosing disease;
(ii) performing surgery;
(iii) performing acupuncture;
(iv) taking x-rays; or
(v) prescribing or dispensing a drug, as defined in Section 58-37-2.

(11) "Physical therapy aide" means a person who:
(a) is trained, on-the-job, by a licensed physical therapist; and
(b) provides routine assistance to a licensed physical therapist or licensed physical therapist assistant, while the licensed physical therapist or licensed physical therapist assistant practices physical therapy, within the scope of the licensed physical therapist's or licensed physical therapist assistant's license.

(13)(a) "Testing" means a standard method or technique used to gather data regarding a patient that is generally and nationally accepted by physical therapists for the practice of physical therapy.

(b) "Testing includes measurement or evaluation of:
(i) muscle strength, force, endurance, or tone;
(ii) cardiovascular fitness;
(iii) physical work capacity;
(iv) joint motion, mobility, or stability;
(v) reflexes or autonomic reactions;
(vi) movement skill or accuracy;
(vii) sensation;
(viii) perception;
(ix) peripheral nerve integrity;
(x) locomotor skills, stability, and endurance;
(xi) posture;
(xii) body mechanics;
(xiv) limb length, circumference, and volume;
(xv) thoracic excursion and breathing patterns;
(xvi) activities of daily living related to physical movement and mobility;
(xvii) functioning in the physical environment at home or work, as it relates to physical movement and mobility; and

(xviii) neural muscular responses.
(14) “Trigger point dry needling” means the stimulation of a trigger point using a dry needle to treat neuromuscular pain and functional movement deficits.
(15) "Therapeutic intervention" includes:
(a) therapeutic exercise, with or without the use of a device;
(b) functional training in self-care, as it relates to physical movement and mobility;
(c) community or work integration, as it relates to physical movement and mobility;
(d) manual therapy, including:
(i) soft tissue mobilization;
(ii) therapeutic massage; or
(iii) joint mobilization, as defined by the division, by rule;
(e) prescribing, applying, or fabricating an assistive, adaptive, orthotic, prosthetic, protective, or supportive device;
(f) airway clearance techniques, including postural drainage;
(g) integumentary protection and repair techniques;
(h) wound debridement, cleansing, and dressing;
(i) the application of a physical agent, including:
(i) light;
(ii) heat;
(iii) cold;
(iv) water;
(v) air;
(vi) sound;
(vii) compression;
(viii) electricity; and
(ix) electromagnetic radiation;
(j) mechanical or electrotherapeutic modalities;
(k) positioning;
(l) instructing or training a patient in locomotion or other functional activities, with or without an assistive device;
(m) manual or mechanical traction;
(n) correction of posture, body mechanics, or gait; and
(o) trigger point dry needling.

Part 2 - Physical Therapy Licensing Board
58-24b-201. Physical Therapy Licensing Board - Creation - Membership - Duties.
(1) There is created the Physical Therapy Licensing Board, consisting of three licensed physical therapists, one physical therapist assistant, and one member of the general public.

Part 3 - Licensing
58-24b-301. Authority to practice physical therapy.
A person may not engage in the practice of physical therapy, unless the person is:
(1) licensed under this chapter and practices within the scope of that license; or
(2) exempted from the licensing requirements of this chapter.

58-24b-302. Licensure.
(1) An applicant for a license as a physical therapist shall:
(a) be of good moral character;
(b) complete the application process, including the payment of fees;

(c) submit proof of graduation from a professional physical therapist education program that is accredited by a recognized accreditation agency;
(d) after complying with Subsection (1)(c), pass a licensing examination;
(e) be able to read, write, speak, understand, and be understood in the English language and demonstrate proficiency to the satisfaction of the board if requested by the board; and
(f) meet any other requirements established by the division, by rule.

(2) An applicant for a license as a physical therapist assistant shall:
(a) be of good moral character;
(b) complete the application process, including the payment of fees set by the division, in accordance with Section 63J-1-504, to recover the costs of administering the licensing requirements relating to physical therapist assistants;
(c) submit proof of graduation from a physical therapist assistant education program that is accredited by a recognized accreditation agency;
(d) after complying with Subsection (2)(c), pass a licensing examination;
(e) be able to read, write, speak, understand, and be understood in the English language and demonstrate proficiency to the satisfaction of the board if requested by the board; and
(f) meet any other requirements established by the division, by rule.

(3) An applicant for a license as a physical therapist who is educated outside of the United States shall:
(a) be of good moral character;
(b) complete the application process, including the payment of fees; and
(c)
(i) provide satisfactory evidence that the applicant graduated from a professional physical therapist education program that is accredited by a recognized accreditation agency; or
(ii)
(A) provide satisfactory evidence that the applicant graduated from a physical therapist education program that prepares the applicant to engage in the practice of physical therapy, without restriction;
(B) provide satisfactory evidence that the education program described in Subsection (3)(c)(ii)(A) is recognized by the government entity responsible for recognizing a physical therapist education program in the country where the program is located; and
(C) pass a credential evaluation to ensure that the applicant has satisfied uniform educational requirements;
(d) after complying with Subsection (3)(c), pass a licensing examination;
(e) be able to read, write, speak, understand, and be understood in the English language and demonstrate proficiency to the satisfaction of the board if requested by the board; and
(f) meet any other requirements established by the division, by rule.

(4) The division shall issue a license to a person who holds a current unrestricted license to practice physical therapy in a state, district, or territory of the United States of America, other than Utah, if the person:
(a) is of good moral character;
(b) completes the application process, including payment of fees;
(c) is able to read, write, speak, understand, and be understood in the English language and demonstrate proficiency to the satisfaction of the board if requested by the board.

(5) (a) Notwithstanding Subsection 58-1-307(1)(c), an individual may not engage in an internship in physical therapy, unless the person is:

(i) certified by the division; or

(ii) exempt from licensure under Section 58-24b-304.

(b) The provisions of Subsection (5)(a) apply, regardless of whether the individual is participating in the supervised clinical training program for the purpose of becoming a physical therapist or a physical therapist assistant.

58-24b-303. Term of license - Renewal - Temporary license for physical therapist assistant.

(1) A license issued under this chapter shall be issued in accordance with a two year renewal cycle established by rule. The division may, by rule, extend or shorten a license renewal process by one year in order to stagger the renewal cycles that the division administers.

(2) At the time of license renewal, the licensee shall provide satisfactory evidence that the licensee completed continuing education competency requirements, established by the division, by rule.

(3) If a license renewal cycle is shortened or extended under Subsection (1), the division shall increase or reduce the required continuing education competency requirements accordingly.

(4) A license issued under this chapter expires on the expiration date indicated on the license, unless the license is renewed under this section.

(5) Notwithstanding any other provision of this chapter, the division may, by rule, grant a temporary license, that expires on July 1, 2014, as a physical therapist assistant to an individual who:

(a) was working as a physical therapist assistant in Utah before July 1, 2009; and

(b) complies with the requirements described in Subsections 58-24b- 302(2)(a), (b), (c), (e), and (f).

58-24b-304. Exemptions from licensure.

(1) In addition to the exemptions from licensure described in Section 58-1-307, as modified by Subsection 58-24b-302(5), a person may engage in acts that constitute the practice of physical therapy without a license issued under this chapter if:

(a) the person is licensed under another law of the state to engage in acts that constitute the practice of physical therapy if that person does not:

(i) claim to be a physical therapist;

(ii) claim to be a provider of any type of physical therapy that is outside of the scope of practice of the license that is issued to the person; or

(iii) engage in any acts that constitute the practice of physical therapy that are outside of the scope of practice of the license that is issued to the person;

(b) the person practices physical therapy, under federal law, in:

(i) the United States armed services;

(ii) the United States Public Health Service; or

(iii) the Veteran's Administration;

(c) the person is:

(i) licensed as a physical therapist in:

(A) a state, district, or territory of the United States, other than Utah; or

(B) a country other than the United States; and

(ii)
(A) teaching, demonstrating, or providing physical therapy in connection with an educational seminar, if the person engages in this conduct in Utah no more than 60 days per calendar year;
(B) practicing physical therapy directly related to the person's employment with, or contact with, an established athletic team, athletic organization, or performing arts company that plays, practices, competes, or performs in Utah no more than 60 days per calendar year; or
(C) providing consultation by telecommunication to a physical therapist;

(d) the person:
(i) (A) is licensed as a physical therapist assistant under federal law; and
(B) practices within the scope of practice authorized by federal law for a physical therapist assistant; or
(ii) (A) is licensed as a physical therapist assistant in:
(I) a state, district, or territory of the United States, other than Utah; or
(II) a country other than the United States; and
(B) (I) practices within the scope of practice authorized for a physical therapist assistant by the jurisdiction described in Subsection (1)(d)(ii)(A); and
(II) within the limitations for the practice of physical therapy described in Subsection (1)(c)(ii); or

(e) the person:
(i) is a physician, licensed under Title 58, Chapter 67, Utah Medical Practice Act;
(ii) is a physician, licensed under Title 58, Chapter 58, Utah Osteopathic Medical Practice Act; or
(iii) is a chiropractic physician, licensed under Title 58, Chapter 73, Chiropractic Physician Practice Act.

(2) A person who is exempted from licensure under Subsection (1)(b) may practice animal physical therapy without a license under this section if the person:
(a) is authorized to practice animal physical therapy under federal law; and
(b) practices animal physical therapy within the scope of practice authorized by federal law.

(3) A person who is exempted from licensure under Subsection (1)(c) may practice animal physical therapy without a license under this section if the person:
(a) is authorized to practice animal physical therapy in:
(i) a state, district, or territory of the United States, other than Utah; or
(ii) a country other than the United States; and
(b) practices animal physical therapy:
(i) within the scope of practice for the jurisdiction described in Subsection (3)(a) where the person is authorized to practice animal physical therapy; and
(ii) within the limitations for the practice of physical therapy described in Subsection (1)(c)(ii).

Part 4 - Practice of Physical Therapy

58-24b-401. Authority and ethical standards of a licensed physical therapist and licensed physical therapist assistant - Function of a physical therapy aide.

(1) A licensed physical therapist:
(a) is fully authorized to practice physical therapy; and
(b) shall adhere to the standards of ethics described in

(i) the American Physical Therapy Association's Code of Ethics and Guide for Professional Conduct; and
(ii) rule.

(2) A licensed physical therapist assistant:
(a) is authorized to practice physical therapy;
(i) under the on-site supervision or general supervision of a licensed physical therapist; and
(ii) within the scope of practice of a licensed physical therapist assistant, as described in this chapter and by rule;
(b) shall adhere to the standards of ethics described in:
(i) the American Physical Therapy Association's Code of Ethics and Guide for Professional Conduct; and
(ii) rule; and
(c) may not be supervised by any person other than a licensed physical therapist.

(3) (a) A physical therapy aide may not engage in the practice of physical therapy.
(b) Notwithstanding Subsection (3)(a), a physical therapy aide may provide routine assistance to:
(i) a licensed physical therapist while the licensed physical therapist engaged in the practice of physical therapy, if the physical therapy aide is under the on-site supervision of the licensed physical therapist; or
(ii) a licensed physical therapist assistant while the licensed physical therapist assistant engages in the practice of physical therapy, within the scope of the licensed physical therapist assistant's license, if the physical therapy aide is:
(A) under the general or on-site supervision of a licensed physical therapist; and
(B) under the on-site supervision of the licensed physical therapist assistant.

58-24b-402. Patient care and management.

(1) In practicing physical therapy, a licensed physical therapist shall:
(a) manage all aspects of the physical therapy of a patient under the licensed physical therapist's care;
(b) perform the initial evaluation and documentation for each patient;
(c) perform periodic reevaluation and documentation for each patient;
(d) perform physical therapy interventions that require immediate and continuous examination and evaluation throughout the intervention;
(e) perform all therapeutic intervention on a patient that is outside of the standard scope of practice of a licensed physical therapist assistant or a physical therapy aide;
(f) determine the therapeutic intervention to be performed by a licensed physical therapist assistant under the on-site supervision or general supervision of the licensed physical therapist to ensure that the therapeutic intervention is safe, effective, efficient, and within the scope of practice of the licensed physical therapist assistant;
(g) conduct the discharge of each patient and document for each patient, at the time of discharge, the patient's response to therapeutic intervention; and
(h) provide accurate documentation of the billing and services provided.

(2) A physical therapist assistant or a physical therapy aide may not:
(a) perform a physical therapy evaluation or assessment;
(b) identify or label a physical impairment or injury;
(c) design a plan of care for a patient;
(d) perform the joint mobilization component of manual therapy; or

(e) perform the sharp selective debridement component of wound management.
(3) Subsection (2)(d) does not apply to:
(a) simple joint distraction techniques or stretching; or
(b) a stretch or mobilization that can be given as part of a home exercise program.

58-24b-403. Administration of a prescription drug.
(1) A licensed physical therapist may purchase, store, and administer topical and aerosol medications that require a prescription only as provided in this section.
(2) A licensed physical therapist may purchase, store, and administer:
(a) topically applied medicinal agents, including steroids and analgesics, for wound care and for musculoskeletal treatment, using iontophoresis or phonorphoresis; and
(b) aerosols for pulmonary hygiene in an institutional setting, if a licensed respiratory therapist is not available in, or within a ten mile radius of, the institution.
(3) A licensed physical therapist may only purchase, store, or administer a medication described in this section pursuant to a written prescription issued by a practitioner who is licensed to prescribe that medication.
(4) This section does not authorize a licensed physical therapist to dispense prescription drug.

58-24b-405. Animal physical therapy.
(1) Subject to Subsection 58-28-307(12)(b), a licensed physical therapist may practice animal physical therapy if the licensed physical therapist completes at least 100 hours of animal physical therapy training and education, which shall include:
(a) 50 hours of on-the-job training under the supervision of a licensed veterinarian;
(b) completion of a quadruped anatomy course; and
(c) continuing education for the required hours remaining.
(2) Subject to Subsection 58-28-307(12)(b), a licensed physical therapist assistant may practice animal physical therapy, within the scope of the licensed physical therapist assistant's practice, if the licensed physical therapist assistant:
(a) is under the on-site supervision or general supervision of a physical therapist who has complied with the requirements of Subsection (1); and
(b) completes at least 100 hours of animal physical therapy training and education, which shall include:
(i) 50 hours of on-the-job training under the supervision of a licensed veterinarian;
(ii) completion of a quadruped anatomy course; and
(iii) continuing education for the required hours remaining.

Part 5 - Unlawful and Unprofessional Conduct
58-24b-501. Unlawful conduct.
In addition to the conduct described in Subsection 58-1-501(1), "unlawful conduct" includes:
(1) practicing physical therapy, unless the person:
(a) is licensed under this chapter to practice physical therapy and practices within the scope of that license; or
(b) is exempt from licensure under Section 58-24b-304;
(2) practicing animal physical therapy, unless the person is:
(a) authorized to practice animal physical therapy under Section 58-24b- 405; or
(b) authorized to practice animal physical therapy under Subsection 58-24b-304(1)(a), (2), or (3);

(3) representing oneself as, or using the title of, a physical therapist, unless the person is:
(a) a licensed physical therapist; or
(b) (i) licensed as a physical therapist in a jurisdiction other than Utah;
(ii) does not represent oneself as being a physical therapist licensed in Utah; and
(iii) exempt from licensure under Section 58-24b-304;
(4) representing oneself as, or using the title of, a physical therapist assistant, unless the person:
(a) is a licensed physical therapist assistant; or
(b) (i) is licensed as a physical therapist assistant in a jurisdiction other than Utah;
(ii) does not represent oneself as being a physical therapist assistant licensed in Utah; and
(iii) is exempt from licensure under Section 58-24b-304; and

58-24b-502. Unprofessional conduct.
In addition to the conduct described in Subsection 58-1-501(2), "unprofessional conduct" includes:
(1) using or employing the services of an individual to assist a person licensed under this chapter in a manner that is not in accordance with:
(a) generally recognized practices, standards, or ethics of the profession for which the person is licensed; or
(b) the requirements of this chapter or rule;
(2) failure by a person licensed under this chapter to confine the person's conduct to that which:
(a) the person is competent to perform, by education, training, and experience; and
(b) is within the scope of practice permitted under this chapter or rule;
(3) failure to supervise a licensed physical therapist assistant or a physical therapy aide in accordance with the requirements of this chapter or rule; and

58-24b-503. Lawful and unlawful use of titles and terms - Unlawful advertising or promotion.
(1) A person who is a licensed physical therapist shall use the letters "PT" in connection with the person's name or business in order to indicate that the person is a licensed physical therapist.
(2) A person who is a licensed physical therapist assistant shall use the letters "PTA" in connection with the person's name or business in order to indicate that the person is a licensed physical therapist assistant.
(3) It is unlawful for a person who is not a licensed physical therapist, a licensed physical therapist assistant, or a person described in Subsection 58-24b-304(1)(e) to:
(a) use, in connection with the person's name or business, any of the following words or abbreviations:
(i) physical therapy, except to the extent that the word is used to describe conduct that a person is licensed to engage in under another law of the state;
(ii) physiotherapy; or
(iii) any other word, abbreviation, or insignia, indicating or implying, directly or indirectly, that the person practices physical therapy; or
(b) offer, provide, or bill a person for:
(i) physical therapy services or anything that is characterized as physical therapy services; or

(ii) physiotherapy services or anything that is characterized as physiotherapy services.

(4) It is unlawful for a person who is not a licensed physical therapist to:

(a) except as provided in Subsection (6), use, in connection with the person's name or business, any of the following words or abbreviations:

(i) physical therapist;

(ii) physiotherapist;

(iii) PT;

(iv) DPT;

(v) MPT; or

(vi) any other word, abbreviation, or insignia, indicating or implying, directly or indirectly, that the person is a physical therapist or physiotherapist;

(b) advertise that a person who is not a licensed physical therapist is a physical therapist or physiotherapist; or

(c) promote a person who is not a licensed physical therapist as a physical therapist or physiotherapist.

(5) It is unlawful for a person who is not a licensed physical therapist assistant to:

(a) use, in connection with the person's name or business, any of the following words or abbreviations:

(i) physical therapist assistant;

(ii) physiotherapist assistant;

(iii) PTA; or

(iv) any other word, abbreviation, or insignia, indicating or implying, directly or indirectly, that the person is a physical therapist assistant or a physiotherapist assistant;

(b) advertise that a person who is not a licensed physical therapist assistant is a physical therapist assistant or a physiotherapist assistant; or

(c) promote a person who is not a licensed physical therapist assistant as a physical therapist assistant or physiotherapist assistant.

(6) Subsection (4)(a) does not prohibit a person from using a word or abbreviation described in Subsection (4)(a) in connection with the person's business, if the person employs a physical therapist at the person's business.

58-24b-504. Reporting unlawful or unprofessional conduct - Immunity - Confidentiality.

(1) A person who is aware that a person who is licensed under this chapter has violated a provision of this chapter, or a rule made pursuant to this chapter, shall report the violation to the division.

(2) A person who makes a good faith report under Subsection (1) is immune from direct or derivative civil liability for making the report.

(3) The division, the board, or a member of the division or the board, may not disclose the identity of a person who makes a report under this section, unless the disclosure is:

(a) essential to the conduct of an investigation or hearing; or

(b) ordered by a court of competent jurisdiction.

58-24b-505. Trigger point dry needling – Experience required

(1) A physical therapist may practice trigger point dry needling if the physical therapist:

(a) has a held a license to practice physical therapy under this chapter, and has actively practices physical therapy, for two years;

(b) has successfully completed a course in trigger point dry needling that:

(i) is approved by the division; and
(ii) includes at least 300 total course hours; including at least:
(A) 54 hours of in-person instruction; and
(B) 250 hours supervised patient treatment sessions.
(c) files a certificate of completion of the course described with the division;
(d) registers with the division as a trigger point dry needling practitioner; and
(e) meets any other requirement established by the division.

Utah Physical Therapy Practice Act Rule R156-24b

The following is an abridged version of the Utah Physical Therapy Practice Act Rule R156-24b. To read the document in its entirety, please go to: http://www.dopl.utah.gov/laws/R156-24b.pdf

R156-24b-102. Definitions.

(6) "Joint mobilization", as used in Subsection 58-24b-102(14)(d), means passive and active movements of the joints of a patient, including the spine, to increase the mobility of joint systems; but, does not include specific vertebral adjustment and manipulation of the articulation of the spine by those methods or techniques which are generally recognized as the classic practice of chiropractic.
(7) "Routine assistance", as used in Subsections 58-24b-102(10) and 58-24b-401(3)(b) means:
(a) engaging in assembly and disassembly, maintenance and transportation, preparation and all other operational activities relevant to equipment and accessories necessary for treatment; and
(b) providing only that type of elementary and direct patient care which the patient and family members could reasonably be expected to learn and perform.
(8) "Supportive personnel", as used in Subsection R156-24b-503(1), means a physical therapist assistant or a physical therapy aide and does not include a student in a physical therapist or physical therapist assistant program.
(9) "Unprofessional conduct" as defined in Title 58, Chapters 1 and 24b, is further defined, in accordance with Subsection 58-1-203(1)(e), in Section R156-24b-502.

R156-24b-303b. Continuing Education.

(1) Required Hours. In accordance with Subsection 58-24b-303(2), during each two-year renewal cycle commencing on June 1 of each odd numbered year:
(a) A physical therapist shall be required to complete not fewer than 40 contact hours of continuing education of which a minimum of **two*** contact hours must be completed in ethics/law. (*Utah physical therapy licensees were previously required to complete 3 hours of ethics/law each licensure period. On January 1, 2017, changes were enacted to the Utah Physical Therapy Practice Act Rule. The new rule decreased the ethics/law requirement to 2 hours.) http://www.rules.utah.gov/publicat/code/r156/r156-24b.htm
(b) A physical therapist assistant shall be required to complete not fewer than 20 contact hours of continuing education of which a minimum of **two*** contact hours must be completed in ethics/law. (*Utah physical therapy licensees were previously required to complete 3 hours of ethics/law each licensure period.

On January 1, 2017, changes were enacted to the Utah Physical Therapy Practice Act Rule. The new rule decreased the ethics/law requirement to 2 hours.) http://www.rules.utah.gov/publicat/code/r156/r156-24b.htm

(c) Examples of subjects to be covered in an ethics/law course for physical therapists and physical therapist assistants include one or more of the following:

(i) patient/physical therapist relationships;
(ii) confidentiality;
(iii) documentation;
(iv) charging and coding;
(v) compliance with state and/or federal laws that impact the practice of physical therapy; and
(vi) any subject addressed in the American Physical Therapy Association Code of Ethics or Guide for Professional Conduct.

(d) The required number of contact hours of continuing education for an individual who first becomes licensed during the two year renewal cycle shall be decreased in a pro-rata amount.

(e) The Division may defer or waive the continuing education requirements as provided in Section R156-1-308d.

(2) A continuing education course shall meet the following standards:

(a) Time. Each contact hour of continuing education course credit shall consist of not fewer than 50 minutes of education. Licensees shall only receive credit for lecturing or instructing the same course up to two times. Licensees shall receive one contact hour of continuing education for every two hours of time spent:

(i) lecturing or instructing a course;
(ii) in a post-professional doctorate or transitional doctorate program; or
(iii) in a post-professional clinical residency or fellowship approved by the American Physical Therapy Association.

(b) Course Content and Type. The course shall be presented in a competent, well organized, and sequential manner consistent with the stated purpose and objective of the course.

(i) The content of the course shall be relevant to the practice of physical therapy and shall be completed in the form of any of the following course types:

(A) department in-service;
(B) seminar;
(C) lecture;
(D) conference;
(E) training session;
(F) webinar;
(G) internet course;
(H) distance learning course;
(I) journal club;
(J) authoring of an article or textbook publication;
(K) poster platform presentation;

(L) specialty certification through the American Board of Physical Therapy Specialties;
(M) post-professional clinical residency or fellowship approved by the American Physical Therapy Association;
(N) post-professional doctorate from a CAPTE accredited program;
(O) lecturing or instructing a continuing education course; or
(P) study of a scholarly peer-reviewed journal article.

(ii) The following limits apply to the number of contact hours recognized in the following course types during a two year license renewal cycle:
(A) a maximum of 40 contact hours for initial specialty certification through the American Board of Physical Therapy Specialties (ABPTS);
(B) a maximum of 40 contact hours for hours spent in a post-professional doctorate or transitional doctorate CAPTE accredited program;
(C) a maximum of 40 contact hours for hours spent in a post-professional clinical residency or fellowship approved by the American Physical Therapy Association;
(D) a maximum of half of the number of contact hours required for renewal for lecturing or instructing in courses meeting these requirements;
(E) a maximum of ten percent of the number of contact hours required for renewal for supervision of a physical therapist or physical therapist assistant student in an accredited college program and the licensee shall receive one contact hour of credit for every 80 hours of clinical instruction;
(F) a maximum of 15 contact hours required for renewal for serving as a clinical mentor for a physical therapy residency or fellowship training program at a credentialed program and the licensee shall receive one contact hour of credit for every ten hours of residency or fellowship;
(G) a maximum of half of the number of contact hours required for renewal for online or distance learning courses that include examination and issuance of a completion certificate;
(H) a maximum of 12 contact hours for authoring a published, peer-reviewed article;
(I) a maximum of 12 contact hours for authoring a textbook chapter;
(J) a maximum of ten contact hours for personal or group study of a scholarly peer-reviewed journal article;
(K) a maximum of six contact hours for authoring a non-peer reviewed article or abstract of published literature or book review; and
(L) a maximum of six contact hours for authoring a poster or platform presentation.

(c) Provider or Sponsor. The course shall be approved by, conducted by, or under the sponsorship of one of the following:
(i) a recognized accredited college or university;
(ii) a state or federal agency;

(iii) a professional association, organization, or facility involved in the practice of physical therapy; or
(iv) a commercial continuing education provider providing a course related to the practice of physical therapy.
(d) Objectives. The learning objectives of the course shall be clearly stated in course material.
(e) Faculty. The course shall be prepared and presented by individuals who are qualified by education, training, and experience.
(f) Documentation. Each licensee shall maintain adequate documentation as proof of compliance with this Section, such as a certificate of completion, school transcript, course description, or other course materials. The licensee shall retain this proof for a period of three years after the end of the renewal cycle for which the continuing education is due.
(i) At a minimum, the documentation shall contain the following:
(A) the date of the course;
(B) the name of the course provider;
(C) the name of the instructor;
(D) the course title;
(E) the number of contact hours of continuing education credit; and
(F) the course objectives.
(ii) If the course is self-directed, such as personal or group study or authoring of a scholarly peer-reviewed journal article, the documentation shall contain the following:
(A) the dates of study or research;
(B) the title of the article, textbook chapter, poster, or platform presentation;
(C) an abstract of the article, textbook chapter, poster, or platform presentation;
(D) the number of contact hours of continuing education credit; and
(E) the objectives of the self-study course.
(6) Extra Hours of Continuing Education. If a licensee completes more than the required number of contact hours of continuing education during the two-year renewal cycle specified in Subsection (1), up to ten contact hours of the excess may be carried over to the next two year renewal cycle. No education received prior to a license being granted may be carried forward to apply towards the continuing education required after the license is granted.

R156-24b-502. Unprofessional Conduct.
Unprofessional conduct includes:
(1) violating, as a physical therapist, any provision of the American Physical Therapy Association's Code of Ethics for the Physical Therapist.
(2) violating, as a physical therapist, any provision of the American Physical Therapy Association's Guide for Professional Conduct.
(3) not providing supervision, as a physical therapist, as set forth in Section R156-24b-503

(4) violating, as a physical therapist assistant, any provision of the American Physical Therapy Association's Standards of Ethical Conduct for the Physical Therapist Assistant.
(5) violating, as a physical therapist assistant, any provision of the American Physical Therapy Association's Guide for Conduct of the Physical Therapist Assistant.

R156-24b-503. Physical Therapist Supervisory Authority and Responsibility.
In accordance with Section 58-24b-404, a physical therapist's supervision of a physical therapist assistant or a physical therapy aide shall meet the following conditions:
(1) a full-time equivalent physical therapist can supervise no more than three full-time equivalent supportive personnel unless approved by the board and Division; and
(2) a physical therapist shall provide treatment to a patient at least every tenth treatment but no longer than 30 days from the day of the physical therapist's last treatment day, whichever is less.

Case Studies

Case Study #1 - Confidentiality

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

Is this a breach in confidentiality?

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

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

John's first statement discloses the name of person receiving care, and his second statement reveals private patient medical information. Certainly, as the

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

Case Study #2 – Informed Consent

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

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

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

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

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

In order for the patient's consent to be valid, they must be considered competent to make the decision at hand and their consent must be voluntary. The therapist should make clear to the patient that they are participating in a decision, not merely signing a form. With this understanding, the informed consent process should be seen as an invitation for them to participate in their health care decisions. The therapist is also generally obligated to provide a recommendation and share their reasoning process with the patient. Comprehension on the part of the patient is equally as important as the information provided. Consequently, the

discussion should be carried on in layperson's terms and the patient's understanding should be assessed along the way.

The therapist's actions in this case were not sufficient. None of the required information was offered to the patient. The most important thing the therapist failed to explain to the patient was the consequences of non-treatment. The patient cannot make an informed decision regarding therapy without this information. It could be argued that her decision to refuse therapy may have changed had she known that one of the consequences of this decision could be the development of secondary complications. (i.e. increased risk of morbidity or mortality).

Case Study #3- Medical Necessity

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

Is limiting care in this manner ethical?

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

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

Case Study #4 – Conflicts of Interest

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

Does this represent a conflict of interest?

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

Case Study #5 – Relationships with Referral Sources

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

Is this an ethical arrangement?

No, this agreement is not ethical. The most notable infraction involves offering to designate and compensate the physician as the Medical Director contingent upon the number of referrals he sends. It is perfectly acceptable (and required in some instances) to have a physician as a Medical Director; however, compensating the Medical Director based on their referral volume is unethical. Another area of concern is the rent. At first glance, the rent amount of $17/sq ft seems fair because it was a compromise between the two parties. However, closer scrutiny reveals this to be unethical. The fair market value for rent has been established as $20/sq ft. (Larry's current rental agreement with his landlord) By discounting the doctor $3/sq ft on his rent, Larry is giving a referral source something of value.

It is unethical for a physical therapist to offer anything of value to physicians or any other referral source in direct response for the referral of patients or services. This includes cash, rebates, gifts, discounts, reduced rent, services, equipment, employees, or marketing. Many mistakenly believe that it is a normal acceptable business practice to offer these things to referral sources. It is not. In most states, the practice is not only unethical, but it is also illegal. Exchanges of valued items or services between therapists and referral sources must never have any relationship to the referral of patients. Goodwill gifts of nominal value

are acceptable provided that no correlation can be made between the magnitude or frequency of the gift giving and referral patterns. All business agreements and transactions should always be well documented and most importantly, reflect fair market value.

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Ethics & Jurisprudence – Utah Physical Therapy

Post-Test

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

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

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

4. 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 _____.
    A. physical therapist
    B. physical therapist or physician
    C. physical therapist, physician, or other qualified health care professional
    D. None of the above

5. The primary goal of the informed consent process is _____.
    A. Provide protection for health care providers against litigation
    B. Ensure that patients have an opportunity to be informed participants in decisions about their health.
    C. Improve efficiency and accuracy throughout the health care system.
    D. Facilitate the practice of evidence-based medicine.

6. Gifts from companies to physical therapists are acceptable only when ___.
    A. the primary purpose is the enhancement of patient care and medical knowledge
    B. each professional in the field receives the same gift without regard to previous product usage
    C. the company is introducing a new product or service to the market.
    D. permission is received from the professional's employer

7. A Utah licensed physical therapist assistant may legally perform which of the following?
    A. Physical therapy assessment
    B. Identification of physical impairment
    C. Sharp selective debridement
    D. Simple joint distraction

8. Which of the following statements regarding Utah physical therapy continuing education requirements is FALSE?
    A. Physical therapists must complete at least 40 hours of continuing education each two year renewal cycle.
    B. PTs & PTAs must complete at least 2 hours of Ethics/Law education each two-year renewal cycle.
    C. Continuing education courses must be pre-approved by either the Utah Board of Physical Therapy or the Utah Physical Therapy Association.
    D. Utah physical therapy licensees may take a maximum of 50% of their continuing education through online or distance learning courses.

9. A physical therapist must provide treatment to a patient at least every ___ treatment day, but no longer than ____ days from the day of the PT's last treatment day; whichever is less.
    A. tenth; 30
    B. fifteenth; 30
    C. twentieth; 45
    D. twentieth; 60

10. It is unethical for a physical therapist to _____.
    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 mew physical therapy techniques and interventions

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