

Ethics - Oklahoma Physical Therapy

Ethics – Oklahoma Physical Therapy

Goals & Objectives

Course Description

“Ethics – Oklahoma Physical Therapy” is an online continuing education course for Oklahoma licensed physical therapists and physical therapist assistants. The course focuses on defining moral, ethical, and legal behavior of physical therapy professionals. The information presented includes discussions on the theoretical basis for ethical decision-making, informed consent, confidentiality, conflicts of interest, selected sections of the Oklahoma Physical Therapy Practice Act and Title 435, Chapter 20 of the Oklahoma Administrative Code, the APTA's Code of Ethics and Guide for Professional Conduct, and hypothetical ethics case studies.

Course Rationale

This course was developed to educate, promote and facilitate ethical and legal behavior by Oklahoma licensed physical therapists and physical therapist assistants. It is intended to meet the 3 hour Ethics CE requirement as mandated by 435:20-9-2 (b)(2) of the Oklahoma Administrative Code.

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. define the ethical decision making model
3. identify and apply the APTA's standards of professional ethical conduct
4. define the parameters of informed consent
5. identify components of effective provider-patient communication
6. differentiate between appropriate and inappropriate relationships
7. define conflict of interest and identify situations that demonstrate it
8. identify the principles of confidentiality
9. apply the ethical decision making model to clinical situations to determine appropriate professional behavior
10. recognize all of the rights and responsibilities of physical therapy licensure as defined by the Oklahoma Physical Therapy Practice Act and Title 435, Chapter 20 of the Oklahoma Administrative Code.

Course Provider – Innovative Educational Services

Course Instructor - Michael Niss, DPT

Target Audience - Oklahoma licensed physical therapists and physical therapist assistants

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

Course Prerequisites – None

Method of Instruction/Availability – Online asynchronous course available continuously.

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

Continuing Education Credits – Three hours of continuing education credit

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Ethics Overview

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

Ethics are important on several levels.

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

Ethics vs. Morals

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

Ethical Questions

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

Ethics Theories

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

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Utilitarianism

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

Social Contract Theory

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

Deontological or Duty Theory

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

Ethical Intuitionism

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

Ethical Egoism

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

Natural Law Theory

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

Virtue Ethics

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

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

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

Beneficence: the duty to do good.

Confidentiality: the duty to respect privacy of information.

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

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

Nonmaleficence: the duty to cause no harm.

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

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

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

Veracity: the duty to tell the truth.

Model for Ethical Decision Making

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

Are my actions legal?

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

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

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

Are my actions ethical?

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

Are my actions fair?

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

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

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

APTA Code of Ethics

Preamble

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

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

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

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

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

Principles

Principle #1:

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

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

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

Principle #2:

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

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

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

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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.

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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.

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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.

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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.

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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

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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.

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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.

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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

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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

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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.

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Professionalism

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

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

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

Boundaries

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

Legal Aspects

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

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

Other Problematic Relationships

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

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

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

Gifts and Conflict of Interest

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

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

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

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

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

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

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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

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- 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.

Oklahoma Administrative Code, Title 435, Chapter 20

(To read the O.A.C., Title 435, Chapter 20 in its entirety, go to:
http://www.okmedicalboard.org/physical_therapists/download/456/PTRULES.pdf)

Subchapter 3. Licensure of Physical Therapists and Assistants

435:20-3-2. Criteria for disqualification as a physical therapist

No license will be issued to a Physical Therapist who has:

- (1) Provided Physical Therapy treatment other than upon referral of a duly licensed physician or surgeon, dentist, chiropractor or podiatrist.
- (2) Used drugs or alcohol excessively, affecting competence or judgment, unless is able to provide satisfactory evidence of rehabilitation and participation efforts;
- (3) Been convicted of a felony or of a crime involving moral turpitude;
- (4) Been adjudged mentally incompetent unless competency has been legally reestablished;
- (5) Conducted himself/herself in a manner considered improper by recognized acceptable standards of moral and ethical conduct.

435:20-3-3. Criteria for disqualification as a physical therapy assistant

No license will be issued to a Physical Therapy Assistant who has:

- (1) Practiced other than under the direction and supervision of a licensed Physical Therapist;
- (2) Used drugs or alcohol excessively, affecting competence or judgment, unless is able to provide satisfactory evidence of rehabilitation and participation efforts;
- (3) Been convicted of a felony or of a crime involving moral turpitude;
- (4) Been adjudged mentally incompetent unless competency has been legally reestablished;
- (5) Conducted himself/herself in a manner considered improper by recognized acceptable standards of moral and ethical conduct.

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435:20-3-6. Requirements for renewal and re-entry

(a) **Renewal of license.** In order to renew the license, each Physical Therapist and Physical Therapist Assistant shall:

- (1) complete the renewal application;
- (2) pay the required fee as set out in OAC 435:1-1-7(a)(2);
- (3) complete a jurisprudence examination prepared by the Board focusing on the areas of the Oklahoma Physical Therapy Practice Act and related Oklahoma Administrative Code;
- (4) and meet requirements for continuing education as set out in Subchapter 9 of this Chapter.

(b) **Re-entry requirements.** Pursuant to 59 O.S. §495h, physical therapists and physical therapist assistants with licenses lapsed more than three months wishing to re-enter the practice of physical therapy will be required to file an application on forms provided by the Board and submit documentation of continuing competence. Physical therapists and physical therapist assistants may be required to meet one or more of the following requirements:

- (1) Personal appearance before the Advisory Committee;
- (2) Work under the direct supervision of a physical therapist licensed in the State of Oklahoma for at least one month (at least 22 days) for each year license was lapsed, not to exceed twelve (12) months. The applicant must obtain authorization from the Board before beginning the period of supervised practice. On completion of the period of supervised practice, the applicant will provide to the Board an adequate performance evaluation from the supervising physical therapist;
- (3) Participation in continuing education activities directed towards maintaining or improving clinical knowledge and skills;
- (4) Achieve a passing score on an examination approved by the Board.
- (5) Complete a jurisprudence examination prepared by the Board focusing on the areas of the Oklahoma Physical Therapy Practice Act and related Oklahoma Administrative Code.

Subchapter 5. Regulation of Practice

435:20-5-1. Display certificate

All persons licensed under Title 59 O.S., Sections 887.1 through 887.17 and practicing in the State shall prominently display the certificate of licensure and evidence of a current renewal in the primary place of practice.

435:20-5-2. Working under supervision

Recent physical therapist or physical therapist assistant graduates who have completed eligibility requirements for examination and submitted all required forms and fees for examination may work in a Physical Therapy facility under the direct, on the premises, supervision and direction of a licensed Physical Therapist.

435:20-5-3. Aiding and abetting the unlicensed practice

It shall be unlawful for any person to aid or abet, directly or indirectly, the practice of physical therapy by any person not duly authorized under the laws of Oklahoma.

435:20-5-4. Titles used for physical therapist assistants

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Any person holding a license as a Physical Therapist Assistant may use the title "Physical Therapist Assistant", "Registered Physical Therapist Assistant" or "Licensed Physical Therapist Assistant", or the letters "PTA", "RPTA", or "LPTA".

435:20-5-5. Screening and educational procedure; statutory terms defined

Screening and educational procedures as described in the Physical Therapy Practice Act are defined as follows:

- (1) "To educate" means to train by formal instruction and supervised practice.
- (2) "To screen" means to examine methodically in order to separate into different groups to identify problems which can be managed within the expertise of a licensed physical therapist.

435:20-5-6. Physical therapists under probation

Physical therapists on probation shall not supervise physical therapy assistants or new graduates who require supervision under 435:20-5-2.

435:20-5-8. Unprofessional conduct – Grounds for disciplinary action

- (a) The Physical Therapy Advisory Committee may recommend to the Board to revoke or take other disciplinary action against a licensee or deny a license to an applicant for unprofessional conduct.
- (b) Acts that constitute unprofessional conduct include, but are not limited to:
 - (1) Procuring aiding or abetting a criminal operation.
 - (2) Habitual intemperance or the habitual use of habit-forming drugs.
 - (3) Conviction of a felony or of any offense involving moral turpitude.
 - (4) Conviction or confession of a crime involving violation of the laws of this state.
 - (5) Dishonorable or immoral conduct that is likely to deceive, defraud, or harm the public.
 - (6) Aiding or abetting, directly or indirectly, the practice of physical therapy by any person not duly authorized under the laws of this state.
 - (7) Engaging in physical conduct with a patient that is sexual in nature, or in any verbal behavior that is seductive or sexually demeaning to a patient.
 - (8) Participation in fraud, abuse and/or violation of state or federal laws.
 - (9) Any conduct which potentially or actually jeopardizes a patient's life, health or safety.
 - (10) Verbally or physically abusing patients.
 - (11) Discriminating in the rendering of patient care.
 - (12) Negligence while in practice of physical therapy or violating the "Standards of Ethics and Professional Conduct" adopted by the Board.
 - (13) Habitual intemperance or addicted use of any drug, chemical or substance that could result in behavior that interferes with the practice of physical therapy and the responsibilities of the licensee.
 - (14) Unauthorized possession or use of illegal or controlled substances or pharmacological agents without lawful authority or prescription by an authorized and licensed independent practitioner of the State of Oklahoma.
 - (15) Fraudulent billing practices and/or violation of Medicare and Medicaid laws or abusive billing practices.
 - (16) Improper management of medical records, inaccurate recording, falsifying or altering or failing to complete documentation of patient records.
 - (17) Falsely manipulating patient's records or forging a prescription for medication/drugs, or presenting a forged prescription.

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- (18) Aiding, abetting or assisting any other person to violate or circumvent any law, rule or regulation intended to guide the conduct of a physical therapist or physical therapist assistant.
 - (19) Being judged mentally incompetent by a court of competent jurisdiction.
 - (20) Failing to timely make application for license renewal.
 - (21) Falsifying documents submitted to the Physical Therapy Committee or the Oklahoma State Board of Medical Licensure and Supervision.
 - (22) Obtaining or attempting to obtain a license, certificate or documents of any form as a physical therapist or physical therapist assistant by fraud or deception.
 - (23) Cheating on or attempting to subvert the national physical therapy examination or skills assessment tests.
 - (24) Leaving a patient care assignment without properly advising the appropriate personnel.
 - (25) Violating the confidentiality of information or knowledge concerning a patient.
 - (26) Conviction of, or confession of or plea of no contest to a felony or misdemeanor.
 - (27) While engaged in the care of a patient, engaging in conduct with a patient, patient family member, or significant other that is seductive or sexually demeaning/exploitive in nature.
 - (28) Failure to report through proper channels the unsafe, unethical or illegal practice of any person who is providing care.
 - (29) Failure to furnish to the Board, its investigators or representatives, information lawfully requested by the Board.
 - (30) Failure to cooperate with a lawful investigation conducted by the Board.
 - (31) Violation of any provision(s) of the Physical Therapy Practice Act or the rules and regulations of the board or of an action, stipulation, agreement or order of the Board.
 - (32) Failure to report to the Board any adverse action taken against him or her by another licensing jurisdiction (United States or foreign), by any governmental agency, by any law enforcement agency, or by an court for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section.
- (c) A physical therapist or physical therapist assistant who knowingly allows or participates with individual(s) who are in violation of the above will be prohibited from supervising other physical therapy practitioners for so long as the Board deems appropriate, and may themselves be subject to disciplinary action pursuant to their conduct.

435:20-5-9. Standards of Ethics and Professional Conduct

In the conduct of their professional activities, the physical therapist and physical therapist assistant shall be bound by the following ethical and professional principles. Physical therapists and physical therapist assistants shall:

- (1) Respect the rights and dignity of all individuals and shall provide compassionate care.
- (2) Demonstrate behavior that reflects integrity, supports objectivity, and fosters trust in the profession and its professionals.
- (3) Comply with state and/or federal laws that govern and relate to physical therapy practice.
- (4) Exercise sound professional judgment and perform only those procedures or functions in which they are individually competent and that are within the scope of accepted and responsible practice. A physical therapist shall not delegate to a less qualified person any activity that requires the unique skill, knowledge, and judgment of the physical therapist. A physical therapist assistant shall provide selected physical

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therapy interventions only under the supervision and direction of the evaluating physical therapist. A physical therapist assistant shall make judgments that are commensurate with their education and legal qualifications as a physical therapist assistant.

- (5) Actively maintain and continually improve their professional competence and represent it accurately.
- (6) Maintain high standards by following sound scientific procedures and ethical principles in research and the practice of physical therapy.
- (7) Seek reasonable remuneration for physical therapy practice.
- (8) Provide and make available accurate and relevant information to patients about their care and maintain patient confidentiality.
- (9) May provide information to the public about societal benefits of physical therapy services. A physical therapist may advertise his/her services to the public.
- (10) Refuse to participate in illegal or unethical acts, and shall refuse to conceal illegal, unethical or incompetent acts of others.
- (11) Endeavor to address the health needs of society through pro bono services and/or community health services.
- (12) Respect the rights, knowledge and skills of colleagues and other healthcare professionals.

435:20-5-10. Referrals

- (a) A licensed physical therapist who has received a referral from a person licensed as an allopathic physician, osteopathic physician, physician assistant, dentist, chiropractor or podiatrist may extend or reinstitute physical therapy for the patient named on the referral for a time period not to exceed ninety (90) days after the origination of the referral, unless a longer duration of physical therapy services is requested by the referring health care professional, provided that:
- (1) the diagnosis or symptom listed on the referral is the same as the reason for the extension or reinstatement of the physical therapy treatment;
 - (2) the referring health care professional is notified of the extension or reinstatement of the treatment within five (5) business days of the date of the extension or reinstatement of the physical therapy treatment; and
 - (3) the patient involved has made or is making sufficient improvement in symptoms or function to warrant the extension or reinstatement of the physical therapy treatment without first being seen or re-evaluated by the by the referring health care professional.
- (b) The physical therapist may not make a medical diagnosis or diagnosis of disease.
- (c) If the physical therapist determines, based on the physical therapy screening and evaluation, that the patient's condition is outside the scope of the physical therapy practice, the physical therapist may not initiate, extend, or reinstitute treatment and must immediately refer the patient to a licensed health care professional.
- (d) If the physical therapist determines, based on reasonable evidence that appropriate improvement in symptoms or function has not been made within 60 days of the date on the referral, the physical therapist shall consult with or refer the patient back to the health care professional who originated the referral.
- (e) The provisions of paragraphs (a) – (d) of this section do not apply if the patient is receiving physical therapy services pursuant to the Individuals with Disabilities Education Improvement Act of 2004, as may be amended, and the Rehabilitation Act of 1973, Section 504, as may be amended.

Subchapter 7. Supervision of Physical Therapist Assistants

435:20-7-1. Direction and Supervision of Physical Therapist Assistants

(a) Responsible supervision.

(1) Physical therapists have a duty to provide therapy services that protect the public safety and maximize the availability of their services. The physical therapist assistant is the only individual permitted to assist in selected treatment interventions. A physical therapist assistant shall be supervised by a specific physical therapist or group of physical therapists working in the same practice setting or physical facility. A physical therapist assistant may not be supervised by any other person including those licensed in other professions. The physical therapist of record is accountable and responsible at all times for the direction of the actions of the physical therapist assistant when treating his/her patient. When determining the extent of assistance the physical therapist assistant can provide, the physical therapist should consider:

- (A) the physical therapist assistant's experience and skill level
- (B) the patient/client criticality and complexity
- (C) the setting in which the care is being delivered
- (D) the predictability of the patient/client outcomes
- (E) the needed frequency of re-examination

(2) A physical therapist shall not delegate to a less qualified person any service that requires the skill, knowledge and judgment of a physical therapist. For each date of service, a physical therapist shall provide all therapeutic interventions that require the expertise of a physical therapist and shall determine when assistive personnel may be used to provide delivery of services in a safe, effective, and efficient manner for each patient.

(A) A physical therapist assistant shall work under a physical therapist's direct or general supervision. A physical therapist assistant may document care provided without the co-signature of the supervising physical therapist. The physical therapist assistant will respond to acute changes in the patient's physiological state and report these findings promptly to the physical therapist. Contact, or attempts to contact the physical therapist of record, will be documented in the medical record.

(B) A physical therapist and a physical therapist assistant may use physical therapy aides for designated and immediately supervised routine tasks. The physical therapist shall not delegate the same type and level of duties to the physical therapy aide as are delegated to the physical therapist assistant. A physical therapy aide shall work under immediate supervision of the physical therapist or physical therapist assistant who is continuously on-site and present in the facility.

(b) Patient Care Management. Upon accepting a patient for provision of services, the physical therapist becomes the Physical Therapist of Record for that patient and is solely responsible for managing all aspects of the physical therapy plan of care for that patient. The Physical Therapist of Record shall:

- (1) Perform the initial examination and evaluation
- (2) Establish a plan of care and remain responsible to provide and/or supervise the appropriate interventions outlined in the plan of care.
- (3) Perform the re-examination/re-evaluation of the patient in light of their goals and revision of the plan of care when indicated. This will be performed no less frequently than:

(A) every 30 days in acute care, outpatient, inpatient rehabilitation and long term care settings with documented case consultation no less frequently than every 15 days;

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(B) every 60 days in home health settings with documented case consultation no less frequently than every 30 days;

(C) every 90 days in consultative DDSD with documented case consultation no less frequently than every 45 days;

(D) every 10th visit for DDSD for patients under 21 years of age with documented case consultation no less frequently than every 5th visit;

(E) every 60 days in educational settings with documented case consultation no less frequently than every 30 days;

(4) Establish the discharge plan and provide or review the documentation of the discharge summary prepared by the physical therapist assistant.

(5) A physical therapist's responsibility for patient care management shall include oversight of all documentation for services rendered to each patient, including awareness of fees charged or reimbursement methodology used. A physical therapist shall also be aware of what constitutes unreasonable or fraudulent fees.

(c) Designation of a new Physical Therapist of Record. In the event that the Physical Therapist of Record can no longer assume these responsibilities, care must be turned over to another physical therapist who will become the new Physical Therapist of Record. The Therapist of Record must make sure that the new Physical Therapist of Record is authorized and qualified to receive the patient, must obtain acceptance from the receiving physical therapist, document the hand-over of the patient and maintain the care and responsibility of the patient until the new Physical Therapist of Record is acknowledged in the documentation.

(d) Designation and responsibilities of Supervising Physical Therapist and Alternate Supervising Physical Therapist. Both the physical therapist and physical therapist assistant are responsible for completion of the Form #5, Verification of Supervision.

(1) A Form #5, Verification of Supervision must be completed annually for each clinical practice setting in which the physical therapist assistant works, identifying the supervising physical therapist for the physical therapist assistant. The physical therapist assistant will be responsible to inquire of their supervising physical therapist(s) or the Board, the number of persons being supervised by that physical therapist. If responsible supervision is not practiced, both the supervising physical therapist and the physical therapist assistant are in violation of this rule. Any revised or new Form #5 for a physical therapist assistant at a clinical practice setting will supersede the existing Form #5 for that setting. A physical therapist assistant will not practice in any clinical setting without the necessary Form #5. It is the responsibility of both physical therapists and physical therapist assistants to notify the Board of any changes to a Form #5 that they have signed.

(2) A physical therapist will not supervise and utilize more than four (4) licensed personnel or applicants for licensure. Only three (3) may be physical therapist assistants or applicants for physical therapist assistant licensure. Any of the four (4) may be applicants for physical therapist licensure. This total is inclusive of all geographic locations or employing agencies.

(3) For each practice setting in which he or she works, the physical therapist assistant and the supervising physical therapists must indicate on the Form #5, Verification of Supervision which of the method of supervision described in (A) or (B) below will be employed in that practice setting.

(A) A physical therapist will provide direct or general supervision of a physical therapist assistant and will be listed on the Form #5 as the supervising physical therapist. In the event that he or she is unable to provide supervision, a supervising physical therapist may:

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(i) temporarily delegate the supervision of up to three licensed physical therapist assistants to an alternate supervising physical therapist who agrees to provide consultation to the physical therapist assistant(s) for existing plans of care for a period of time not to exceed thirty (30) days. In this event, a new Form #5 is not required, but the alternate supervising physical therapist must be identified as the Therapist of Record in the documentation.

(ii) designate a new Therapist of Record, as in 435:20-7-1-(c) above, to assume full responsibility of the plan of care who may, if they so choose, delegate to a physical therapist assistant under their supervision as listed on their Form #5.

(B) A group of physical therapists, working in the same practice setting may provide supervision to a physical therapist assistant providing the following conditions are met:

(i) all supervising physical therapists are listed on a Form #5 for the physical therapist assistant.

(ii) the ratio of physical therapists to physical therapist assistants in that practice setting does not exceed the ratio of one (1) physical therapist to three (3) physical therapist assistants or applicants for licensure at any given time.

(iii) The group director, who must be a licensed physical therapist or physical therapist assistant, is identified and assumes responsibility for accurate information on the Form #5 and the appropriate ratio of physical therapist to physical therapist assistants. The Board may assign disciplinary action to the clinical director or all members of the group for violation of the supervision rules.

(e) Supervision of additional physical therapist assistants. In unique cases, a physical therapist may petition the Chair of the Physical Therapy Committee to receive permission to supervise additional physical therapist assistants or applicants for licensure, but this decision to supervise additional assistive personnel must be reviewed and approved by the committee at the next scheduled meeting..

(f) **Limits of practice for the physical therapist assistant.** The physical therapist assistant may not:

(1) Specify, other than to the Physical Therapist of Record, perform or interpret definitive (decisive, conclusive, final) evaluative and assessment procedures. Definitive evaluation procedures may not be recommended to anyone other than the patient's physical therapist, unless previously approved by the physical therapist.

(2) Alter overall treatment, goals and/or plan.

(3) Recommend adaptive equipment, assistive devices, or alterations to architectural barriers to persons other than a physical therapist.

(4) File discharge documents for permanent record until approved by a physical therapist.

(5) Perform duties or tasks for which he/she is not trained.

Subchapter 9. Continuing Education

435:20-9-1. Definitions

The following words and terms, when used in this Subchapter, shall have the following meaning, unless the content clearly indicates otherwise:

"APTA" means the American Physical Therapy Association.

"Asynchronous instruction" means instructional interaction whereby instructional delivery and learner participation occurs other than simultaneously, offering either a delayed opportunity or no opportunity for instructional feedback.

"Board" means the Board of Medical Licensure and Supervision.

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"Compliance period" means the initial compliance period from February 1, 1998 through January 31, 2000 and each successive two calendar year period from January 1, 2000 to December 31, 2002.

"Continuing education" means those appropriate learning experiences physical therapists and physical therapist assistants undertake to expand their scope of knowledge beyond the basic preparation for the profession of physical therapy and these experiences should be referenced to one of four areas: administration, education, patient care, or research.

"One (1) contact hour" means one sixty (60) minute instructional period.

"One (1) Continuing Education Unit or CEU" means ten (10) contact hours.

"OPTA" means the Oklahoma Physical Therapy Association.

"Pre-approval" means the continuing education experience has received approval prior to the end of the compliance period.

"Synchronous instruction" means instructional interaction conducted in real time where the instructional delivery and learner participation occurs concurrently with an immediate opportunity for instructional feedback.

435:20-9-2. Continuing education requirements for renewal

(a) Beginning with the renewal period ending January 31, 2000 and every two years thereafter, the applicant for renewal of licensure shall sign a statement indicating whether or not continuing education requirements have been fulfilled for the preceding two-year period.

(b) Effective January 1, 2004 and every two years thereafter, physical therapists will be required to show proof of forty (40) approved contact hours and Physical Therapist Assistants will be required to show proof of thirty (30) approved contact hours.

(1) At least half of the required hours must be Category A as set out in subsection 435:20-9-3(b) except as provided in 435:20-9-3(a)(3).

(2) Three of the required hours must contain ethics education that includes the APTA Guide for Professional Conduct and the APTA Code of Ethics.

(3) No continuing education hours may be carried over from one compliance period to another.

(c) Any applicant for renewal who cannot meet the requirements for continuing education may not renew until deficient hours are obtained and verified. Additionally, within the next compliance period the licensee will be required to obtain double the required hours of approved continuing education. At least half of the required hours must be Category A. Proof of meeting the additional requirements, as verified by an audit, will be required in order to renew at the end of the next compliance period. Failure to meet these additional requirements will result in disciplinary action.

(d) Each licensee is responsible for maintaining evidence/proof/record of participation in a continuing education experience for a minimum of four years. Copies of such proof shall be submitted to the Board upon request. Such proof shall include:

(1) date, place, course title, schedule, presenter(s), etc.,

(2) number of contact hours for activity,

(3) proof of completion, such as abstracts, certificates of attendance, or other certification of completion.

(e) Any physical therapist or physical therapist assistant initially licensed in Oklahoma during the second year of an accounting period shall be exempt from the continuing education requirements for that first renewal period.

(f) The Physical Therapy Committee shall conduct random audits of the continuing education records of the number of licensees that time and resources permit. The

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Physical Therapy Committee may appoint a sub-committee to review audits and requests for approval of continuing education experiences and make recommendations to the Physical Therapy Committee for disposition.

(g) Penalties for failure to comply with continuing education requirements may be assessed after notice and hearing as required by law. Penalties may include imposition of additional continuing education contact hours, probation of license, suspension of license, or revocation of license.

(h) Failure to maintain records of continuing education rebuts the presumption that continuing education requirements have been completed.

(i) Misrepresenting compliance with continuing education requirements constitutes a fraudulent application.

435:20-9-3. Continuing education categories

(a) Approval for continuing education.

(1) To receive initial approval for a continuing education offering of either category, submission of an Application for Approval of Continuing Physical Therapy Education form is required.

(2) Individual participants are responsible for maintaining these records.

(3) Physical therapists and physical therapist assistants working less than 250 hours per year may request permission from the to earn all contact hours from Category B and/or Category C.

(4) Pre-approval is required for guaranteed credit under either Category.

(b) Category A – synchronous educational opportunities. At least half of the required contact hours must be acquired from Category A.

(1) Synchronous education – Attendance at a synchronous education course with real-time interaction between the course instructor and physical therapists or physical therapist assistants, with opportunity for immediate feedback.

(2) Presentation of program - A licensee who presents an original continuing education program targeted towards peers and other health care professionals may receive continuing education credit once per compliance period.

(3) Post Graduate Studies - Successful completion of post graduate education course work related to physical therapy will be awarded continuing education credit of up to 16 contact hours for each college credit hour.

(c) Category B – other.

(1) Opportunities under Category B continuing education include:

(A) Publication - Writing for professional publication may be awarded continuing education credit. Actual number of contact hours granted will be determined by the Committee. Acceptance for publication must occur within the current compliance period. Contact hours will not be approved for repeat publication of the same material.

(i) Each published paper/book and/or chapter/or case study may receive a maximum of fifteen (15) contact hours.

(ii) Each published book review may receive a maximum of ten (10) contact hours.

(B) Study groups - A series of synchronous or asynchronous meetings designed for intense study in a physical therapy related topic. A minimum of four participants and four hours of participation are required for continuing education eligibility. Those seeking approval for a group study project shall submit a full description including an outline of the topics and subtopics, references, or copies of the printed materials, a time and place of study, the methods to be used, the number of hours of credit sought, and any other information relevant to the evaluation of the proposed projects.

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(C) Individualized instruction - This includes home study or Internet courses relating to physical therapy practice extending beyond basic preparation of the licensee. In order to count any individualized instruction toward Category B hours, the licensee must submit proof of a passing score on a post test and a certificate of completion.

(D) Learning opportunities not listed above may be considered for continuing education credit, but will require pre-approval.

(E) Activities not accepted - Examples of activities that will not be accepted include but are not limited to:

(i) Regularly scheduled education opportunities provided within an institution, such as rounds or on-the-job required in-service training such as CPR, blood-borne pathogens, equipment or procedural updates.

(ii) Staff meetings.

(iii) Meetings, workshops or seminars held by personnel with less medical training than registered physical therapists or physical therapist assistants.

(iv) Publications for the lay public.

(v) Presentations to lay groups and non-professionals.

(vi) Teaching personnel, students or staff within one's job requirement.

(vii) Non-educational meetings, entertainment or recreational activities at professional meetings.

(viii) APTA, chapter or section offices or committee appointment.

(d) **Category C. - Federation of State Boards of Physical Therapy's Practice Review Tool.** Actual number of contact hours granted will be determined by the Committee. Preapproval required for credit.

435:20-9-4. Guidelines for the audit process

(a) The Physical Therapy Committee will, each compliance period, randomly or for cause select licensees for verification that all continuing education requirements have been met.

(b) Those being audited have thirty (30) calendar days from the date of the letter of notification to submit proof of continuing education to the Committee.

(c) The Physical Therapy Committee or its appointed sub-committee shall review the documentation of each individual for compliance with established continuing education standards.

(d) Those found to be in compliance shall be notified.

(e) Those found not to be in compliance shall be notified, by certified mail, within five working days following the determination of non-compliance. They will be given specific information concerning areas of deficiency, what further information is needed to bring them into compliance, given opportunity to submit additional documentation and/or appear in person at the next Physical Therapy Committee meeting.

(f) A summarized report shall be submitted to the Physical Therapy Committee listing the names of those audited who are in compliance with continuing education requirements. Those not in compliance shall be listed with notation of deficiencies found and/or recommendations.

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Oklahoma Physical Therapy Practice Act

(To read the Oklahoma PT Practice Act in its entirety, go to:
www.okmedicalboard.org/physical_therapists/download/730/PTLAW_eff_11-1-14.pdf)

887.13. Refusal, suspension or revocation of license

The State Board of Medical Licensure and Supervision may refuse to issue or renew, or may suspend or revoke a license to any person, after notice and hearing in accordance with rules and regulations promulgated pursuant to the Physical Therapy Practice Act and the provisions of the Administrative Procedures Act of the Oklahoma Statutes who has:

1. Practiced physical therapy for workers' compensation claims other than under the referral of a physician, surgeon, dentist, chiropractor or podiatrist duly licensed to practice medicine or surgery, a physician assistant or in the case of practice as a physical therapist assistant, has practiced other than under the direction of a licensed physical therapist;
2. Treated or attempted to treat ailments or other health conditions of human beings other than by physical therapy as authorized by the Physical Therapy Practice Act;
3. Failed to refer patients to other health care providers if symptoms are known to be present for which physical therapy treatment is inadvisable or if symptoms indicate conditions for which treatment is outside the standards of practice as specified in the rules and regulations promulgated by the Board pursuant to the provisions of the Physical Therapy Practice Act;
4. Used drugs, narcotics, medication, or intoxicating liquors to an extent which affects the professional competency of the applicant or licensee;
5. Been convicted of a felony or of a crime involving moral turpitude;
6. Obtained or attempted to obtain a license as a physical therapist or physical therapist assistant by fraud or deception;
7. Been grossly negligent in the practice of physical therapy or in acting as a physical therapist assistant;
8. Been adjudged mentally incompetent by a court of competent jurisdiction and has not subsequently been lawfully declared sane;
9. Been guilty of conduct unbecoming a person licensed as a physical therapist or physical therapist assistant or guilty of conduct detrimental to the best interests of the public or the profession;
10. Been guilty of any act in conflict with the ethics of the profession of physical therapy;
- or
11. Had a license suspended or revoked in another state

887.17. Referrals by physicians and surgeons - Agents - Exceptions

A. 1. Except for workers compensation claims, any person licensed under the Physical Therapy Practice Act as a physical therapist shall be able to evaluate and treat human ailments by physical therapy on a patient without a referral from a licensed health care practitioner for a period not to exceed thirty (30) days. Treatment may be provided by a physical therapist assistant under the supervision of a physical therapist. Any treatment provided beyond the thirty-day period shall be only under the referral of a person licensed as a physician or surgeon with unlimited license, or the physician assistant of the person so licensed, and Doctors of Dentistry,

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Chiropractic and Podiatry, with those referrals being limited to their respective areas of training and practice.

2. A physical therapist may provide services within the scope of physical therapy practice without a physician referral to children who receive physical therapy services pursuant to the Individuals with Disabilities Education Improvement Act of 2004, as may be amended, and the Rehabilitation Act of 1973, Section 504, as may be amended.

Provided further, a plan of care developed by a person authorized to provide services within the scope of the Physical Therapy Practice Act shall be deemed to be a prescription for purposes of providing services pursuant to the provisions of the Individuals with Disabilities Education Improvement Act of 2004, as may be amended, and Section 504 of the Rehabilitation Act of 1973, as may be amended.

3. Nothing in the Physical Therapy Practice Act shall prevent a physical therapist from performing screening and educational procedures within the scope of physical therapy practice without a physician referral.

4. Nothing in the Physical Therapy Practice Act shall prevent a physical therapist from performing services that are provided for the purpose of fitness, wellness, or prevention that is not related to the treatment of an injury or ailment.

5. Nothing in the Physical Therapy Practice Act shall be construed as authorization for a physical therapist or physical therapist assistant to practice any branch of the healing art.

6. Any person violating the provisions of the Physical Therapy Practice Act shall be guilty of a misdemeanor as per Section 887.16 of this title.

B. 1. The provisions of the Physical Therapy Practice Act are not intended to limit the activities of persons legitimately engaged in the nontherapeutic administration of baths, massage, and normal exercise.

2. The Physical Therapy Practice Act shall not prohibit students who are enrolled in schools of physical therapy approved by the State Board of Medical Licensure and Supervision from performing such work as is incidental to their course of study; nor shall it prevent any student in any recognized school of the healing art in carrying out prescribed courses of study; provided such school is a recognized institution by the statutes of Oklahoma, and its practitioners are duly licensed as prescribed by law.

3. Nothing in the Physical Therapy Practice Act shall apply to any person employed by an agency, bureau, or division of the federal government while in the discharge of official duties, however, if such individual engages in the practice of physical therapy outside the line of official duty, the individual must be licensed as herein provided.

Ethics Case Studies

Case Study #1 - Confidentiality

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

Is this a breach in confidentiality?

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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

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- 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

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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

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seems fair because it was a compromise between the two parties. However, closer scrutiny reveals this to be unethical. The fair market value for rent has been established as \$20/sqft. (Larry's current rental agreement with his landlord) By discounting the doctor \$3/sq ft on his rent, Larry is giving a referral source something of value.

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

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Post-Test

1. _____ is the theory that proposes ethical behavior is a result of developed or inherent character traits.
 - A. Utilitarianism
 - B. Social Contract Theory
 - C. Ethical Intuitionism
 - D. Virtue Ethics
2. Which of the following statements is TRUE?
 - A. All actions that are legal are also morally right.
 - B. All actions that are morally right are also legal.
 - C. Physical therapy ethics vary state by state.
 - D. The APTA Code of Ethics establishes ethical behavior for all physical therapists; including therapists who are not members of the APTA.
3. Which of the following is NOT one of the stated purposes of the APTA's Code of Ethics?
 - A. Provide standards of behavior and performance that form the basis of professional accountability to the public.
 - B. Establish rules that define lawful physical therapy practice.
 - C. Provide guidance for physical therapists facing ethical challenges.
 - D. Establish standards by which the APTA can determine if a physical therapist has engaged in unethical conduct.
4. As per the principles of the APTA's Code of Ethics, it is unethical for a physical therapist to have a sexual relationship with _____.
 - A. their patient
 - B. a PTA working under their supervision
 - C. their physical therapy student intern
 - D. All of the above
5. According to the Standards of Ethical Conduct for the Physical Therapist Assistant, physical therapist assistants shall provide physical therapy services under the direction and supervision of a _____.
 - A. Physical therapist
 - B. physical therapist or physician
 - C. physical therapist, physician, or other qualified health care professional
 - D. None of the above

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6. Gifts from companies to PTs 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. Which of the following statements is FALSE concerning Oklahoma licensed Physical Therapist Assistants?
 - A. A physical therapist assistant must be supervised by a specific physical therapist or group of physical therapists working in the same practice setting or physical facility.
 - B. A physical therapist assistant may document care provided without the cosignature of the supervising physical therapist.
 - C. A Verification of Supervision (Form #5) must be completed biannually for each clinical practice setting in which the PTA works
 - D. Physical therapist assistants may not recommend adaptive equipment or assistive devices to anyone other than a physical therapist.

8. Which of the following is FALSE regarding the CE requirements for Oklahoma licensed physical therapy professionals?
 - A. Three hours of ethics education is required each two-year licensure period.
 - B. The ethics education may only be completed through a Category A (synchronous) continuing education program.
 - C. No continuing education hours may be carried over from one compliance period to another.
 - D. Each licensee is responsible for maintaining evidence/proof/record of participation in a continuing education experience for a minimum of four years

9. Oklahoma licensed physical therapists are permitted to provide care for more than 30 days without a physician's referral to which of the following?
 - A. Children who receive PT services pursuant to the Individuals with Disabilities Education Improvement Act of 2004.
 - B. Individuals in hospice care.
 - C. Residents of long term skilled nursing facilities.
 - D. Indigent individuals receiving Pro Bono services

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 new physical therapy techniques and interventions

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