

FLEX CEUs



Ethics, Laws, Regulations for California Physical Therapists



ETHICS, LAWS & REGULATIONS

CALIFORNIA PHYSICAL THERAPY

OUTLINE

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Introduction

This course fulfills the 2 hour continuing competency requirements for ethics, laws and regulations for physical therapists practicing in the state of California. 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). Regulations pursuant to the state of California will also be reviewed.

Instructor Biography

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Licensure and Regulation

As members of a health care profession, and similar to other health care professions, physical therapists in the United States are licensed and regulated by the states. This information reviews the licensure status of physical therapists in all states and the District of Columbia, describes the purpose and requirements of state licensure, outlines licensing board structure, and provides information about terms and titles. Other than the information specifically about licensure of the physical therapist, the following information also applies to the physical therapist assistant. Information specific to physical therapist assistant licensure/regulation can be found in the section on physical therapist assistants.

State Licensure and Regulation

Physical therapists are licensed in all 50 states and the District of Columbia. State licensure is required in each state in which a physical therapist practices and must be renewed on a regular basis, with a majority of states requiring continuing education or some other continuing competency requirement for renewal. A physical therapist must practice within the scope of physical therapy practice defined by his or her state law governing the licensure and practice of physical therapy (often referred to as the “practice act”).

Purpose and Requirements for State Licensure

State licensure is inherently restrictive for the licensee and exclusive to the particular profession. Only those who “meet and maintain prescribed standards” established by the state’s regulatory board will, for the protection and benefit of the public, be allowed to profess their qualifications and provide their services to the public. The public is dependent upon the state to evaluate and affirm the qualifications for licensure of

physical therapists. One of the main tools used by a state's regulatory entity to determine if a physical therapist has met that threshold is the physical therapist's passage of the National Physical Therapy Exam (NPTE) of the Federation of State Boards of Physical Therapy (FSBPT). The NPTE is the only examination for licensure of physical therapists—all 50 states and the District of Columbia use it. The NPTE is "competency specific" and covers the entire scope of entry level practice, including theory, examination and evaluation, diagnosis, prognosis, treatment intervention, prevention, and consultation that are consistent with the exam blueprint. A formal, systematic process referred to as an "analysis of practice" determines the contents of a licensure examination. This process begins with the identification of work requirements for entry-level practitioners and ends with the development of a formal set of test specifications that delineates the knowledge and skills related to safe and effective entry-level practice. Because physical therapy practice evolves, it is imperative that the licensure examinations be updated on an ongoing basis. Thus, a practice analysis must be conducted periodically to ensure that changes in entry-level requirements are incorporated into the licensure examinations. Revisiting the practice analysis regularly ensures that fewer test questions are included on skill areas of decreasing importance and more test questions address skill areas of increasing importance. The time frame for updating a practice analysis varies by profession; for the physical therapy profession this analysis is conducted at least every 5 years.

Another important qualification for licensure is graduation from an accredited physical therapy education program or a program that is deemed substantially equivalent. The Commission on Accreditation of Physical Therapy Education (CAPTE), recognized by the United States Department of Education as the specialized accrediting agency for physical therapy education programs, sets the quality threshold standards that physical therapist programs must meet in order to be accredited.

State Regulatory Boards

Most jurisdictions have independent state boards of physical therapy, but some jurisdictions' physical therapy boards are part of state medical boards or combined with other professions. There are also a few "super boards," under which all regulatory activities are subordinate to one board, with distinct committees or commissions for the various professions. Independent licensing boards are preferred because they provide the necessary expertise specifically for regulation of physical therapy practice. Most jurisdictions have licensing board members who are appointed by an elected official, usually the governor. Often they include 1 to 2 public members. Smaller jurisdictions may have fewer than 5 total board members, while larger ones have far greater numbers. When a state's practice act is silent on an issue or intervention, the determination of what constitutes practice "beyond the scope" of physical therapy is predominantly the responsibility of licensing board members. Scope of practice changes as contemporary practice evolves, and boards need the latitude to determine the appropriateness of physical therapy procedures as they relate to both established and evolving scope of practice.

The Model Practice Act for Physical Therapy

Over decades the various physical therapy practice acts have contained functional and useful regulatory language but also some problematic language. Most jurisdictional practice acts had their origins in the 1950s and early 1960s, and amendments turned some practice acts into cobbled-together collections of regulatory language that are very diverse in their approach to the basic board responsibility of protecting the public and regulating the profession. FSBPT created *The Model Practice Act for Physical Therapy: A Tool for Public Protection and Legislative Change (MPA)* in 1997 as the preferred tool for revising and modernizing physical therapy practice acts. FSBPT encourages jurisdictions to review, improve, and strengthen practice acts, using the latest edition of the MPA as a resource. The continuing movement to update physical therapy practice acts helps ensure that they provide the legal authority to fully protect the public while effectively regulating the profession. The FSBPT task force that began developing the MPA in 1994 originally envisioned a model act that could be used cafeteria style to allow states to change a specific section of a practice act as needed. While the MPA can be used effectively in this manner, it also is a tightly constructed and integrated model for the regulation of physical therapy. The sections of the MPA complement each other—certain areas of the MPA are indispensable from others, and changes in one area might require modification of a state’s practice act in other areas. The commentary sections of the MPA identify important cross-links in statute language. Since 1997 many states have enacted large portions of and, in some instances, nearly the entire Model Practice Act as their state statute.

Terms and Titles of the Physical Therapy Profession

State regulation restricts how licensees represent themselves, including their use of titles and/or letters, so that they do not mislead the public. For example, a medical or osteopathic physician practices and represents to the public that he or she practices medicine but not dentistry. When practitioners other than physical therapists represent that they are providing “physical therapy” or “physiotherapy,” they are violating the very spirit and core of licensure law by misrepresenting themselves to the public. A claim that “physical therapy” or “physiotherapy” is a generic term is misleading to the public. The protection of these terms is not referring to protection against the use of various physical agents, modalities, or procedures by others, but rather is against the inappropriate labeling of those modalities and procedures as physical therapy. In addition the title “PT” is the professional and regulatory designation that practice acts require physical therapists (and no others) in the United States to use to denote licensure. The use of the initials “DPT” by physical therapists indicates that they have obtained a doctoral degree in physical therapy (DPT). Use of the initials “DPT” should be used in conjunction with the licensure designation of “PT.”

Direct Access to Physical Therapist Services

The vast majority of U.S. jurisdictions have some form of patient access to evaluation and treatment by licensed physical therapists. Access to physical therapist services is critical to ensuring optimum patient functional status and independence. Throughout the experience of obtaining direct access at the state level, physical therapists have been questioned about their ability to identify a patient’s signs and symptoms

correctly, especially those that may represent cancer or other life-threatening conditions, if the patient has not first been screened by a physician. The misguided presumption is that physical therapists are not sufficiently educated or clinically trained to correctly diagnose an underlying pathological condition. This argument falsely concludes that direct access to physical therapists is therefore a threat to the safety of the public. However, a closer look at the facts and evidence proves otherwise.

Physical therapists diagnose impairments, functional limitations and disabilities related to medical conditions, movement dysfunction, and other health-related disorders. Physical therapists do not provide a medical diagnosis. However, they are well-prepared to identify when a patient's signs and symptoms potentially lie outside the scope of physical therapist diagnosis and require a referral to a physician for further diagnostic work-up and identification of underlying pathology. The examination process, routinely employed by physical therapists, ensures that direct access to physical therapists also allows referral to physicians when indicated. With more than 30 years of experience with direct access in the states that permit it, there is absolutely no evidence that physical therapists misinterpret a patient's signs and symptoms as non-pathological leading to serious injury or death. Physical therapist malpractice rates do not differ between states with patient direct access and those with a physician referral requirement. Furthermore, when the number of complaints against physical therapists filed with state licensure boards were examined prior to and after elimination of the physician referral requirement, no increase of complaints centered on patient harm was found. In the research study titled "Documentation of red flags by physical therapists for patients with low back pain," Leerar et al.² studied the frequency of medical screening procedures in 6 private practice clinics. In this retrospective chart review of 160 patients admitted with low back pain, they found that an average of 8 out of the 11 recommended "red flag" screening questions were documented in the chart. The authors noted that this was comparable to or exceeded that of physicians in 5 other studies. In another study, Boissonnault et al.³ reported on 81 patients seen under direct access in a nonprofit, hospital-based outpatient department, and found that retrospective physician review of physical therapist management decisions determined that physical therapist decisions were appropriate 100% of the time. These decisions included making referrals for additional imaging studies, medical consultation, and medication for pain management.² Most referrals from physicians are written as "evaluate and treat." Medical "diagnoses" may only be basket-terms such as "low back pain." Even if a specific medical diagnosis is provided along with an "evaluate and treat" referral, it is incumbent upon the physical therapist to identify the rehabilitation diagnosis. Physical therapists independently design the plan of care and the schedule of implementation. It is the physical therapist who has ultimate responsibility for what interventions will be provided, how many times a week or month the patient will be seen, and the overall duration of the episode of care. Improved patient access does not harm the relationships between physical therapists and physicians. Direct access supports a collaborative model of practice between physicians and physical therapists and will create opportunities that can only enhance patient management, safety, and outcomes. Collaboration is, in many respects, the flip side of the direct access "coin." Historically, physical therapists emerged as a profession within the medical model, not as an alternative to medical care. Traditionally, physical therapists receive a substantial

proportion of their clinical education and training in academic medical centers and hospitals, where team collaboration is paramount. Both physical therapists and physicians have a mutual respect for, and deep understanding of, their complementary roles in patient care. Direct access does not alter that relationship; it merely allows the collaboration to be initiated by the physical therapist at a point in the physical therapy episode of care that is most beneficial to the patient and most cost effective for the health care system.

California Regulations:

California Physical Therapy Practice Act

Laws are created by statutes that originate from legislative bills originally introduced by either the Senate or the Assembly. In 1953 the Physical Therapy Practice Act (Act) was created. The Physical Therapy Practice Act begins with §2600 in the Business and Professions Code (B&P Code) and governs the practice of physical therapy. The Act, statutes, laws and B&P Code could be considered synonymous. The California Physical Therapy Practice Act is available at: http://www.ptbc.ca.gov/laws_regs/laws.shtml

California Code of Regulations, Title 16 Division 13.2

Regulations are standards adopted as rules by the Physical Therapy Board of California to implement, interpret, or make specific the law enforced or administered by the Physical Therapy Practice Act. Regulations have the same effect as law. Failure to comply with either the laws or regulations could result in a citation and/or fine or discipline. The California Code of Regulations is available at: http://www.ptbc.ca.gov/laws_regs/regulations.shtml

Article 4. Physical Therapist Assistants

1398.44. Adequate Supervision Defined.

(a) "Adequate supervision" of a physical therapist assistant shall mean supervision that complies with this section. A physical therapist shall at all times be responsible for all physical therapy services provided by the physical therapist assistant and shall ensure that the physical therapist assistant does not function autonomously. The physical therapist has a continuing responsibility to follow the progress of each patient, and is responsible for determining which elements of a treatment plan may be assigned to a physical therapist assistant.

(b) A physical therapist who performs the initial evaluation of a patient shall be the physical therapist of record for that patient. The physical therapist of record shall remain as such until a reassignment of that patient to another physical therapist of record has occurred. The physical therapist of record shall ensure that a written system of transfer to the succeeding physical therapist exists.

(c) The physical therapist of record shall provide supervision and direction to the physical therapist assistant in the treatment of patients to whom the physical therapist assistant is providing care. The physical therapist assistant shall be able to identify, and communicate with, the physical therapist of record at all times during the treatment of a patient.

(d) A physical therapist assistant shall not:

(1) Perform measurement, data collection or care prior to the evaluation of the patient by

the physical therapist

- (2) Document patient evaluation and reevaluation
- (3) Write a discharge summary
- (4) Establish or change a plan of care
- (5) Write progress reports to another health care professional, as distinguished from daily chart notes
- (6) Be the sole physical therapy representative in any meeting with other health care professionals where the patient's plan of care is assessed or may be modified.
- (7) Supervise a physical therapy aide performing patient-related tasks
- (8) Provide treatment if the physical therapist assistant holds a management position in the physical therapy business where the care is being provided. For purposes of this section, "management position" shall mean a position that has control or influence over scheduling, hiring, or firing.

The prohibitions in subsection (d) above shall not prohibit a physical therapist assistant from collecting and documenting data, administering standard tests, or taking measurements related to patient status.

(e) The physical therapist assistant shall:

- (1) Notify the physical therapist of record, document in the patient record any change in the patient's condition not within the planned progress or treatment goals, and any change in the patient's general condition.

Article 6. Physical Therapy Aides

1399. Requirements for Use of Aides.

- (a) A physical therapy aide is an unlicensed person who may be utilized by a physical therapist in his or her practice by performing non-patient related tasks, or by performing patient related tasks.
- (b) Prior to the aide providing patient related care, a physical therapist shall evaluate and document, the aide's competency level for performing the patient related task that the aide will provide in that setting. The record of competencies shall be made available to the board or any physical therapist utilizing that aide upon request.
- (c) As used in these regulations:
 - (1) A "patient related task" means a physical therapy service rendered directly to the patient by an aide, excluding non-patient related tasks as defined below.
 - (2) A "non-patient related task" means a task related to observation of the patient, transport of patients, physical support only during gait or transfer, housekeeping duties, clerical duties and similar functions.
 - (3) "Under the orders, direction and immediate supervision" means:
 - (A) Prior to the initiation of care, the physical therapist shall evaluate every patient prior to the performance of any patient related tasks by the aide.
 - (B) The physical therapist shall formulate and record in the patient's record a treatment program based upon the evaluation and any other information available to the physical therapist, and shall determine those patient related tasks which may be assigned to an aide.
 - (C) The physical therapist shall assign only those patient related tasks that can be safely and effectively performed by the aide. The physical therapist shall be responsible at all times for the conduct of the aide while the aide is performing "patient related tasks" and

"non-patient related tasks" as defined in this section.

(D) The physical therapist shall provide continuous and immediate supervision of the aide. The physical therapist shall be in the same facility as the aide and in immediate proximity to the location where the aide is performing patient related tasks. The physical therapist shall be readily available at all times to provide immediate advice, instruction or intervention in the care of the patient. When patient related tasks are provided to a patient by an aide the physical therapist shall at some point during the treatment day provide direct service to the patient as treatment for the patient's condition or to further evaluate and monitor the patient's progress.

(E) The physical therapist shall perform periodic re-evaluation of the patient as necessary and make adjustments in the patient's treatment program. The re-evaluation shall be documented in the patient's record.

Article 12. Topical Medications

1399.75. Compliance with Regulations.

A physical therapist may apply or administer topical medications to a patient as set forth in this article.

1399.76. Topical Medications Defined.

As used in this article "topical medications" means medications applied locally to the skin or underlying tissue where there is a break in or absence of the skin where such medications require a prescription or order under federal or state law.

1399.77. Administration of Medications.

Topical medications may be administered by a physical therapist by:

- (a) Direct application;
- (b) Iontophoresis; or
- (c) Phonophoresis.

1399.78. Authorization and Protocols Required.

Topical medications shall be applied or administered by a physical therapist in accordance with this section.

- (a) Any topical medication applied or administered shall be ordered on a specific or standing basis by a practitioner legally authorized to order or prescribe such medication.
- (b) Written protocols shall be prepared for the administration or application of each of the groups of medications listed in Section 1399.79 for which a prescription is required under Federal or State law, which shall include a description of the medication, its actions, its indications and contraindications, and the proper procedure and technique for the application or administration of medication.

1399.79. Authorized Topical Medications.

A physical therapist may apply or administer those topical medications listed in this section in accordance with the provisions of this article:

- (a) Bacteriocidal agents;
- (b) Debriding agents;
- (c) Topical anesthetic agents;

- (d) Anti-inflammatory agents;
- (e) Antispasmodic agents; and
- (f) Adrenocortico-steroids.

Article 13. Continuing Competency Requirements

1399.91. Continuing Competency Required.

(a) As required by this article, a licensee must accumulate 30 hours of continuing competency hours in each license cycle. A licensee must submit evidence of completing those hours to the board in order to renew his or her license. In order to implement this requirement:

(1) For licenses that expire between October 31, 2010 and October 31, 2011, if the renewal is submitted prior to the expiration of the original license, 15 hours of continuing competency shall be completed.

(2) For licenses that expire on and after November 1, 2011, the full 30 hours shall be completed.

(b) For first-time license renewals, if the renewal is submitted prior to the expiration of the original license, the continuing competency hour requirements shall be one-half of the normal cycle. The requirements of 1399.93 shall apply to any renewal under this subsection.

(c) For those licensees accumulating "continuing education units" or "CEUs" under the continuing.

1399.92. Content Standards for Continuing Competency.

Continuing competency hours must be obtained in subjects related to either the professional practice of physical therapy or patient/client management.

(a) The professional practice of physical therapy includes but is not limited to professional accountability, professional behavior and professional development.

(b) Patient/client management includes but is not limited to examination, evaluation and diagnosis and prognosis; plan of care; implementation; education; and discharge.

1399.93. Continuing Competency Subject Matter Requirements

For each renewal cycle, a licensee's continuing competency hours must include the following:

(a) Two hours in ethics, laws and regulations, or some combination thereof, and

(b) Four hours in life support for health care professionals. Such training should be comparable to, or more advanced than, the American Heart Association's Basic Life Support Health Care Provider course.

1399.94. Authorized Pathways for Obtaining Hours.

Continuing competency hours must be obtained through an authorized pathway, which may be either traditional or alternate.

(a) Traditional pathways are those offered by an approved provider. There is no limit to the number of hours which may be accumulated through traditional pathways. The traditional pathways are:

- 1) continuing education courses, including home and self study courses, approved through an agency recognized by the board under the provisions of regulation section 1399.95; and
 - 2) college coursework from an accredited institution.
- (b) Alternate pathways are those offered by an entity other than an approved provider.

1399.97. Record Keeping.

- (a) Each licensee shall keep and maintain records showing that each course or activity for which credit is claimed has been completed. Those records shall reflect the title of the course or activity, the date taken or completed, and the record of participation.
- (b) Each licensee shall retain such documentation for a period of five years after the course or activity concludes.
- (c) Each licensee shall provide copies of such documentation to the board or its designee upon request.

1399.98. Inactive Status.

- (a) Upon written request, the board may grant inactive status to a licensee if, at the time of application for inactive status, the license is current and not suspended, revoked, or otherwise punitively restricted by the board.
- (b) The licensee shall not engage in any activity for which a license is required.
- (c) An inactive license shall be renewed during the same time period in which an active license or certificate is renewed. Any continuing education requirements for renewing a license are waived.
- (d) The renewal fee for an inactive license is the same as the fee to renew an active license.
- (e) To restore an inactive license to an active status, the holder shall do both of the following:
- 1) Pay the renewal and any continuing competency fees.
 - 2) Complete continuing education equivalent to that required for a single renewal period of an active license within the last two years prior to applying to restore the license to active status.
- (f) The inactive status of any licensee does not deprive the board of its authority to institute or continue any disciplinary or enforcement action against the licensee.

1399.99. Exemption from Continuing Competency Requirements.

At the time of applying for renewal of a license, a licensee may request an exemption from the continuing competency requirements. The request for exemption must provide the following information:

- (a) Evidence that during the renewal period prior to the expiration of the license, the licensee was residing in another country for one year or longer, reasonably preventing completion of the continuing competency requirements; or
- (b) Evidence that the licensee was absent from California because of military service for a period of one year or longer during the renewal period, preventing completion of the continuing competency requirements; or
- (c) Evidence that the licensee should be exempt from the continuing competency requirements for reasons of health or other good cause which include:

- 1) Total physical and/or mental disability for one (1) year or more during the renewal period and the inability to work during this period has been verified by a licensed physician or surgeon or licensed clinical psychologist; or
- 2) Total physical and/or mental disability for one (1) year or longer of an immediate family member for whom the licensee had total responsibility, as verified by a licensed physician or surgeon or licensed clinical psychologist.
- d) An exemption under this section shall not be granted for two consecutive renewal periods. In the event a licensee cannot complete continuing competency requirements following an exemption, the licensee may only renew the license in an inactive status.

APTA Code of Ethics

Preamble

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

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

No code of ethics is exhaustive nor can it address every situation. Physical therapists are encouraged to seek additional advice or consultation in instances where the guidance of the Code of Ethics may not be definitive.

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. Throughout the document the primary core values that support specific principles are indicated in parentheses. 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.

Principle #1: Physical therapists shall respect the inherent dignity and rights of all individuals. (Core Values: Compassion, Integrity)

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. (Core Values: Altruism, Compassion, Professional Duty)

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

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

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

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

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

Principle #3: Physical therapists shall be accountable for making sound professional judgments. (Core Values: Excellence, Integrity)

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 healthcare providers, employers, payers, and the public. (Core Value: Integrity)

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 (eg, patients/clients, students, supervisees, research participants, or employees).

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

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

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

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

Principle #5: Physical therapists shall fulfill their legal and professional obligations. (Core Values: Professional Duty, Accountability)

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. (Core Value: Excellence)

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, healthcare 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, life-long learning, and excellence.

Principle #7: Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society. (Core Values: Integrity, Accountability)

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

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

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

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

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

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

Principle #8: Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally. (Core Values: Social Responsibility)

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 over-utilization or under-utilization 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 Guide for Professional Conduct

Purpose

This Guide for Professional Conduct (Guide) is intended to serve physical therapists in interpreting the Code of Ethics for the Physical Therapist (Code) of the American Physical Therapy Association (APTA) in matters of professional conduct. The APTA House of Delegates in June of 2009 adopted a revised Code, which became effective on July 1, 2010. The Guide provides a framework by which physical therapists may determine the propriety of their conduct. It is also intended to guide the professional development of physical therapist students. The Code and the Guide apply to all physical therapists. These guidelines are subject to change as the dynamics of the profession change and as new patterns of health care delivery are developed and accepted by the professional community and the public.

Interpreting Ethical Principles

The interpretations expressed in this Guide reflect the opinions, decisions, and advice of the Ethics and Judicial Committee (EJC). The interpretations are set forth according to topic. These interpretations are intended to assist a physical therapist in applying general ethical principles to specific situations. They address some but not all topics addressed in the Principles and should not be considered inclusive of all situations that could evolve. This Guide is subject to change, and the Ethics and Judicial Committee will monitor and timely revise the Guide to address additional topics and Principles when necessary and as needed.

Preamble to the Code

The Preamble states as follows:

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

1. Define the ethical principles that form the foundation of physical therapist practice in patient/client management, consultation, education, research, and administration.
2. Provide standards of behavior and performance that form the basis of professional accountability to the public.
3. Provide guidance for physical therapists facing ethical challenges, regardless of their professional roles and responsibilities.

4. Educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of the physical therapist.
5. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct.

No code of ethics is exhaustive nor can it address every situation. Physical therapists are encouraged to seek additional advice or consultation in instances where the guidance of the Code of Ethics may not be definitive.

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. Throughout the document the primary core values that support specific principles are indicated in parentheses. 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

Interpretation: Upon the Code of Ethics for the Physical Therapist being amended effective July 1, 2010, all the lettered principles in the Code contain the word “shall” and are mandatory ethical obligations. The language contained in the Code is intended to better explain and further clarify existing ethical obligations. These ethical obligations predate the revised Code. Although various words have changed, many of the obligations are the same. Consequently, the addition of the word “shall” serves to reinforce and clarify existing ethical obligations. A significant reason that the Code was revised was to provide physical therapists with a document that was clear enough such that they can read it standing alone without the need to seek extensive additional interpretation. The Preamble states that “[n]o Code of Ethics is exhaustive nor can it address every situation.” The Preamble also states that physical therapists “are encouraged to seek additional advice or consultation in instances in which the guidance of the Code may not be definitive.” Potential sources for advice and counsel include third parties and the myriad resources available on the APTA Web site. Inherent in a physical therapist’s ethical decision-making process is the examination of his or her unique set of facts relative to the Code.

TOPICS

Respect

Principle 1A states as follows:

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.

Interpretation: 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 states as follows:

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.

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

Patient Autonomy

Principle 2C states as follows:

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.

Interpretation: 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 shall use sound professional judgment in informing the patient/client of any substantial risks of the recommended examination and intervention and shall 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 as follows:

3. Physical therapists shall be accountable for making sound professional judgments.
(Core Values: Excellence, Integrity)

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.

Interpretation: 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 shall be 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 shall establish the plan of care and shall 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 shall 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 shall so inform the patient/client and shall refer the patient/client to an appropriate practitioner.

A physical therapist shall 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 shall 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 shall avoid overutilization of physical therapy services. See Principle 8C.

Supervision

Principle 3E states as follows:

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

Interpretation: 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. Further information on supervision via applicable local, state, and federal laws and regulations (including state practice acts and administrative codes) is available. Information on supervision via APTA policies and resources is also available on the APTA Web site. See Principles 5A and 5B.

Integrity in Relationships

Principle 4 states as follows:

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. (Core Value: Integrity)

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

Reporting

Principle 4C states as follows:

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

Interpretation: When considering the application of “when appropriate” under Principle 4C, keep in mind 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. The EJC Opinion titled Topic: Preserving Confidences; Physical Therapist's Reporting Obligation With Respect to Unethical, Incompetent, or Illegal Acts provides further information on the complexities of reporting.

Exploitation

Principle 4E states as follows:

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

Interpretation: The statement is fairly clear – sexual relationships with their patients/clients, supervisees or students are prohibited. This component of Principle 4 is consistent with Principle 4B, which states:

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). Next, consider this excerpt from the EJC Opinion titled Topic: Sexual Relationships With Patients/Former Patients:

A physical therapist stands in a relationship of trust to each patient and has an ethical obligation to act in the patient’s best interest and to avoid any exploitation or abuse of the patient. Thus, if a physical therapist has natural feelings of attraction toward a patient, he/she must sublimate those feelings in order to avoid sexual exploitation of the patient.

One’s ethical decision making process should focus on whether the patient/client, supervisee or student is being exploited. In this context, questions have been asked about whether one can have a sexual relationship once the patient/client relationship ends. To this question, the EJC has opined as follows:

The Committee does not believe it feasible to establish any bright-line rule for when, if ever, initiation of a romantic/sexual relationship with a former patient would be ethically permissible. The Committee imagines that in some cases a romantic/sexual relationship would not offend ... if initiated with a former patient soon after the termination of treatment, while in others such a relationship might never be appropriate.

Colleague Impairment

Principle 5D and 5E state as follows:

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 the information to the appropriate authority.

Interpretation: 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.

The EJC Opinion titled: Topic: Preserving Confidences; Physical Therapist's Reporting Obligation With Respect to Unethical, Incompetent, or Illegal Acts provides further information on the complexities of reporting.

Professional Competence

Principle 6A states as follows:

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

Interpretation: 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. Additional resources on Continuing Competence are available on the APTA Web site.

Professional Growth

Principle 6D states as follows:

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

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

Charges and Coding

Principle 7E states as follows:

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.

Interpretation: Principle 7E provides that the physical therapist must make sure that the process of documentation and coding accurately captures the charges for services performed. In this context, where charges cannot be determined because of payment methodology, physical therapists may review the House of Delegates policy titled

Professional Fees for Physical Therapy Services. Additional resources on documentation and coding include the House of Delegates policy titled Documentation Authority for Physical Therapy Services and the Documentation and Coding and Billing information on the APTA Web site.

Pro Bono Services

Principle 8A states as follows:

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.

Interpretation: 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. In addition, physical therapists may review the House of Delegates guidelines titled Guidelines: Pro Bono Physical Therapy Services. Additional resources on pro bono physical therapy services are available on the APTA Web site.

8A also addresses supporting organizations to meet health needs. In terms of supporting organizations, the principle does not specify the type of support that is required. Physical therapists may express support through volunteerism, financial contributions, advocacy, education, or simply promoting their work in conversations with colleagues.

References

1. Today's Physical Therapist: A Comprehensive Review of a 21st-Century Health Care Profession; http://www.npta.org/pdf/134_Todays-Physical-Therapy-Profession.pdf; Ethics and Judicial Committee, American Physical Therapy Association, October 1981; Last Amended November 2010; Last Updated 11/30/10.
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