

# CONTINUING EDUCATION for Physical Therapists

## LAWS AND ETHICS FOR THE PHYSICAL THERAPIST

PDH Academy Course #PT-1704 | 2 CE Hours

### Course Abstract

This course provides a practical review of common legal and ethical concepts that pertain to the practice of physical therapy (PT) in the United States. It discusses key ethical principles, addresses foundational documents including the American Physical Therapy Association (APTA) Code of Ethics and the APTA Guide for Professional Conduct, and uses the Realm-Individual Process-Situation (RIPS) Model of Ethical Decision Making to present and discuss case scenarios. It also considers the relationship between ethics and law, and addresses several frequently-arising legal questions.

*NOTE: Links provided within the course material are for informational purposes only. No endorsement of processes or products is intended or implied.*

### Target Audience & Prerequisites

PT, PTA – no prerequisites

### Learning Objectives

By the end of this course, learners will:

- ☐ Recall ethical and legal terms relevant to the practice of physical therapy
- ☐ Recognize the rationale for, and key principles of, the American Physical Therapy Association (APTA) Code of Ethics
- ☐ Identify aspects of the Realm-Individual Process-Situation (RIPS) Model of Ethical Decision Making
- ☐ Distinguish between laws and regulations
- ☐ Recall common legal questions pertaining to the practice of physical therapy

## Timed Topic Outline

- I. Physical Therapy (PT) Ethics (45 minutes)  
Defining PT Practice; The American Physical Therapy Association (APTA)'s Code of Ethics and the APTA Guide for Professional Conduct; Ethical Decision Making
- II. Patient Discharge vs. Abandonment (15 minutes)
- III. Informed Consent (15 minutes)
- IV. Law Review (20 minutes)
- V. Appendices (15 minutes)
- VI. References and Exam (10 minutes)

## Delivery Method

Correspondence/internet self-study with a provider-graded multiple choice final exam. *To earn continuing education credit for this course, you must achieve a passing score of 80% on the final exam.*

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## Course Author Bio and Disclosure

Scott Cheatham, Ph.D., DPT, PT, OCS, ATC, CSCS, is an Assistant Professor in the Division of Kinesiology at California State University Dominguez Hills in Carson, California. He received his Doctor of Physical Therapy (DPT) degree from Chapman University and his PhD in Physical Therapy from Nova Southeastern University. Dr. Cheatham is a Certified Athletic Trainer (ATC) and a board certified specialist in orthopedics (OCS). He also holds several fitness certifications and is a certified ergonomic specialist.

Dr. Cheatham is an expert consultant providing physical therapy expert testimony, chart review, and education for various organizations and government agencies. Dr. Cheatham is an expert for the Physical Therapy Board of California and an approved provider for California PT Laws and Ethics education. He currently serves on professional practice and ethics boards for various organizations.

As an educator and practitioner, Dr. Cheatham is able to provide a unique perspective and understanding of complex physical therapy legal cases. Dr. Cheatham has served as an expert for both plaintiff and defendant cases where he has provided his expert opinion. Dr. Cheatham primarily works as a physical therapy expert witness in the continental United States.

DISCLOSURE: Financial – Scott Cheatham received a stipend as the author of this course. Nonfinancial – No relevant nonfinancial relationship exists.

## Introduction

Welcome to Laws and Ethics for the Physical Therapist. This course provides a practical review of common legal and ethical concepts that pertain to the practice of physical therapy (PT) in the United States (U.S.).

PTs are licensed in all 50 states and the District of Columbia, Puerto Rico, and U.S. Virgin Islands.<sup>1</sup> Most jurisdictions have a license renewal period (e.g. 1-3 years), and many require some amount of continuing education which includes laws and ethics.

*While this course uses laws and regulations from California as examples to illustrate some of the ethical topics discussed, a full examination of PT laws and regulations is beyond its scope. The reader is encouraged to familiarize themselves with PT laws in the state in which they practice.*

## Section I: Physical Therapy Ethics

This section presents the reader with the basic framework for physical therapy professional ethics.

In Part I, we define some basic ethical and moral definitions as they apply to the physical therapist (PT). In Part II, we present the professional code of ethics established by the American Physical Therapy Association (APTA). In Part III, we present the Realm-Individual Process-Situation (RIPS) Model of Ethical Decision Making to help the reader develop a sound approach when confronted with an ethical dilemma.

### Part I: Defining PT Practice

#### Ethics

To every physical therapist, the term ethics may have a different meaning. For the purposes of our discussion, **ethics** can be defined as follows:<sup>2,3</sup>

*“The branch of philosophy that defines what is good for the individual and for society and establishes the nature of obligations, or duties, that people owe themselves and one another. In modern society, ethics define how individuals, professionals, and corporations choose to interact with one another.”*

A more simple definition is that: “*ethics can be considered the moral standards by which people judge behavior.*”<sup>3</sup> However, the definition of what constitutes having “good” ethics in

today's society is often debated.

**Appendix A** provides a list of common ethical terms that support the concepts discussed in this course.

### Morals

As we have defined above, “ethics” is based on moral standards or what we feel is the best behavior for a given situation. **Morals** are based on principles of right and wrong; a moral person conforms to standards of behavior and character based on those principles. Moral values can occur at many different levels such as: personal morality, group morality, societal morality.<sup>3-5</sup>



Thus, our moral beliefs will shape our ethical decision making.

### Professional Ethics

When we analyze both definitions discussed above, we can see that morals define personal or professional character, while ethics represents a system in which those morals are applied. In other words, ethics point to standards or codes of behavior expected by the group to which the individual belongs. This could be national ethics, social ethics, company ethics, professional ethics, or even family ethics. So, while a person's moral code is usually unchanging, the ethics he or she practices can be other-dependent.

Whether it's business or healthcare, each profession has a distinct system, and physical therapy is no exception. Our next section will discuss the American Physical Therapy Association (APTA) code of ethics.

## Part II: Physical Therapy Code of Ethics

Many clinicians may ask: “What are the reasons for creating a code of ethics?” As mentioned in the previous section, professional ethics give the PT a template or blueprint to practice with. Ethical guidelines are designed to help the clinician make sound decisions and ultimately do what's best for the patient. The American Physical Therapy Association (APTA)'s Code of Ethics has created such a blue print for all practicing physical therapists.<sup>6</sup>

The APTA Code of Ethics defines our practice on all levels from personal to organizational, to societal.<sup>6</sup> The purposes of the Code of Ethics are to:<sup>6</sup>

- 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.

The Code of Ethics is based upon five key areas of physical therapy practice: *patient/client management, consultation, education, research, and administration.*

The Code of Ethics is also shaped by a set of **eight principles** and **seven core values** which include: *accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility.*<sup>6</sup> These core values are the foundation of the Code of Ethics and ultimately shape our profession.

They were adopted and took effect on July 1st, 2010 and have not been updated since their inception.<sup>6</sup> Below is a brief listing of these key principles and core values:

Principle #1	Physical therapists shall respect the inherent dignity and rights of all individuals. <i>(Core Values: Compassion, Integrity)</i>
Principle #2:	Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients/clients. <i>(Core Values: Altruism, Compassion, Professional Duty)</i>
Principle #3:	Physical therapists shall be accountable for making sound professional judgments. <i>(Core Values: Excellence, Integrity)</i>
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. <i>(Core Value: Integrity)</i>
Principle #5	Physical therapists shall fulfill their legal and professional obligations. <i>(Core Values: Professional Duty, Accountability)</i>

Principle #6	Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors. <i>(Core Value: Excellence)</i>
Principle #7	Physical therapists shall promote organizational behaviors and business practices that benefit patients/clients and society. <i>(Core Values: Integrity, Accountability)</i>
Principle #8	Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally. <i>(Core Values: Social Responsibility)</i>

**Appendix B** provides a detailed description of the Code of Ethics for the reader to review.

Additional guidance is provided by the APTA Guide for Professional Conduct, which reflects “the opinions, decisions, and advice of the Ethics and Judicial Committee (EJC).”<sup>25</sup> It examines each section of the Code of Ethics, providing interpretations which can aid a PT attempting to apply general principles to specific situations. For example:<sup>25</sup>

### **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.

## **Part III: Ethical Decision Making**

When a physical therapist is confronted with an ethical situation it can be difficult to problem-solve in an organized manner and to develop a clear ethical decision. The complexity that comes with the physical therapist-patient relationship has increased in recent years due to the changes in how we deliver healthcare. These new demands require a more pro-active role with our patient which at times can be complex.

The Realm-Individual Process-Situation (RIPS) Model of Ethical Decision Making has been a foundational model in physical therapy.<sup>4,7</sup> This section introduces the RIPS model to help the clinician develop an organized approach to ethical decision making. This four step model helps clinicians to organize their thoughts when confronted with an ethical situation.<sup>7</sup>

The model includes the following steps:<sup>7</sup>

### **Step I: Recognize and define the ethical issue (realm, individual process and situation)**

The RIPS Model		
<i>Realm</i>	<i>Individual Process</i>	<i>Ethical Situation</i>
Individual	Moral Sensitivity	Problem or Issue
Institutional /Organizational	Moral Judgment	Temptation
Societal	Moral Motivation	Distress
	Moral Courage	Dilemma
		Silence

*Realm: Which area or realm does the ethical issue fall under?*

- *Individual realm:* concerned with the good of the patient/client and focuses on rights, duties, relationships and behaviors between individuals
- *Institutional/organizational realm:* concerned with the good of the organization and focuses on structures and systems that will facilitate their goals
- *Societal realm:* concerned with the common good

*Individual Process: Does the problem appear to be one of the following?*

- *Moral sensitivity:* Recognizing, interpreting, and framing ethical situations.
- *Moral judgment:* Deciding between right and wrong actions.
- *Moral motivation:* Prioritizing ethical values over financial gain or self interest.
- *Moral courage:* Implementing the chosen ethical action even though doing so causes adversity.

*Situation: How do you classify the ethical situation?*

- *Problem or issue:* a situation in which important moral values are being challenged

- **Temptation:** a situation in which a choice must be made between a right action and a wrong action, where the wrong action may benefit the decision-maker in some way
- **Silence:** key parties realize ethical values are being challenged, but do nothing
- **Distress:** there is a structural barrier to doing the right thing
  - Type A: There is a barrier keeping you from doing what you know is right
  - Type B: There is a barrier because something is wrong, but you are not sure what that something is
- **Dilemma**
  - There are two (or more) correct courses of action that cannot both be followed.
  - You are doing something right, and also something wrong.
  - Most often involve ethical conduct (e.g. honoring autonomy vs. preventing harm).
  - May involve conflicting traits of character (e.g. honesty vs. compassion)

## Step II: Reflect upon the situation

- What are the relevant facts and contextual information?
- Who are the major stakeholders?
- What are the potential consequences, intended or unintended?
- What are the relevant laws, duties, and ethical principles?
- What professional guidance do we have?
- What do the “right vs. wrong” tests suggest you should do?
  - The legal test: Did anyone do anything illegal?
  - The “stench” test: Does the situation “smell” wrong?
  - Publicity (the “front page” test): Would any of the parties involved be embarrassed by the truth coming out?
  - Universality (the “mom” test): What would your mom do? Is this the right thing to do regardless of who’s involved?
  - The ethics test: Do the *Code of Ethics*, the *Guide to Professional Conduct*, or *Professionalism in Physical Therapy: Core Values*, say anything about this situation?

## Step III: Decide what to do

- Rule-based: Follow only the principle you want

everyone else to follow (deontological)

- Ends-based: Do whatever produces the greatest good for the greatest number (teleological)
- Care-based: Do unto others as you would have them do unto you (the “golden rule”)

## Step IV: Implement, evaluate, & reassess

- Implement: moral courage (role-play, prepare, imagine)
- Evaluate and reassess
  - Did things turn out the way you expected? What did you do well? Not so well?
  - What were the most challenging aspects of this situation?
  - How did this situation compare with others you have encountered or read about?
  - How will this experience make you a better professional?

Below are two case studies that utilize the RIPS Model.

### Case Study #1<sup>8</sup>

Bruce recently accepted a physical therapist position at a sub-acute care facility after having spent the first 6 years of his career in the acute setting. He generally has enjoyed the change, and loves his much-shorter commuting time. But there’s one thing to which he isn’t adjusting quite so well: the impact he’s beginning to suspect Medicare reimbursement rates are having on patients’ treatment programs.

When a patient is admitted to the facility, Bruce does his part in collecting data, using the Minimum Data Set (MDS) tool that assesses the patient’s current condition based on a variety of measures. After he does this, Cheryl, the facility’s rehabilitation coordinator and a PT who has many years of experience in the sub-acute setting, combines Bruce’s information with data from nursing, speech therapy, and occupational therapy staff to assign the patient a resource utilization group (RUG) level that is based on his or her medical condition and the rehabilitation goals set for that individual. On a few occasions, Bruce has felt the RUG level has not correlated with his own findings.

Initially he feels too inexperienced in the practice setting and too new in working with Cheryl to raise any questions about her conclusions. But the case of Mr. Gaines prompts him to decide to speak up.

Mr. Gaines very recently had a right cerebral vascular accident that resulted in left hemiparesis and made him quite lethargic. His mental faculties are intact, and he has no apparent language difficulties. Bruce feels the prognosis for his long-term recovery is excellent.

Cheryl, however, has assigned Mr. Gaines an extremely high RUG level that requires his receiving 720 minutes



of therapy spread over just 7 days. Because Mr. Gaines doesn't need speech therapy, the 6 hours are to be divided between physical therapy and occupational therapy. Bruce feels he must approach Cheryl about this, because he doesn't think Mr. Gaines can tolerate a program of such intensity at this stage of his recovery. In a couple of weeks, yes, he feels, but not now. Bruce broaches the subject gently ("I was just wondering ..."), so as not to seem presumptuous or put Cheryl on the defensive.

She responds confidently and without hesitation that she knows what she's doing. She encourages Bruce to "be creative" in working with Mr. Gaines and ensuring his compliance. He reluctantly defers and says he'll do his best.

During Bruce's first physical therapy session with Mr. Gaines, however, he finds he barely can keep his patient awake. When Bruce returns for the second session, Mr. Gaines at first refuses to participate, saying he needs rest and advising Bruce to check back with him in a few days. Bruce gets him to relent, but Mr. Gaines can do little during the session. He quickly becomes short of breath and starts sweating, and his resting heart rate increases significantly.

Bruce is concerned. He feels he should be taking things slower with Mr. Gaines, but he's also concerned about meeting the requirements of the RUG level assigned by Cheryl—who, after all, is a veteran sub-acute care PT who presumably, per her own words, knows what she's doing. Bruce likes Cheryl and is reluctant to question her motives. He wonders if he's worrying excessively. He feels torn between what he strongly suspects is the best course of action for his patient and responsibility to his boss and the facility. As he ponders Mr. Gaines' next scheduled visit, he wonders what to do.

### Step I: Recognize and define the ethical issue<sup>7,8</sup>

- **Realm:** Bruce clearly is dealing with an ethical situation at the institutional level. The RUG level appears to him not to have been selected based strictly on the patient's best interests.
- **Individual process:** Bruce had the moral motivation to confront Cheryl about Mr. Gaines's classification but may not have the moral courage to act on his concerns.
- **Implications for action:** Cheryl's judgment has been questioned. One would hope that she would demonstrate the moral sensitivity as a responsible practitioner to reexamine her decisions.
- **Type of ethical situation:** A distress for Bruce. His conscience seems to be telling him the right course of action, but he feels pressure not to follow that course.
- **Barriers:** Cheryl's authority to dictate how he spends his time with Mr. Gaines.

### Step II: Reflect upon the situation<sup>7,8</sup>

- **Major stakeholders:** Bruce, Cheryl, and Mr. Gaines. Additional stakeholders include the facility's administration (which sets guidelines for utilization), other staff PTs, third-party payers, and future patients.
- **Consequences of action or inaction:** Inaction on Bruce's part will result in treating Mr. Gaines at a RUG level that the patient perhaps cannot safely tolerate.
- **Laws broken?** Quite possibly. The statute and/or rules and regulations in most jurisdictions make clear the illegality of selecting inappropriate patient interventions. The apparent violation of criteria for choosing the RUG level raises additional legal issues.
- **Professional guidance:** Principle 4 of the Code of Ethics implores Bruce and Cheryl to exercise sound professional judgment. Core values that must guide their actions include integrity and professional duty.
- **Right-versus wrong tests:** Illegal? Again, quite likely. Situation feels wrong? Yes. Discomfort if information becomes public? Yes. Your parents likely to take action in similar circumstances? Yes. Violations of APTA's professional codes and documents? Yes.

### Step III: Decide what to do<sup>7,8</sup>

Action is required, but what? The fate of Mr. Gaines's recovery may well rest on what course of action Bruce should decide to take.

### Step IV: Implement, evaluate, and reassess

Should Bruce refuse to treat Mr. Gaines at what Bruce deems an inappropriate RUG level, he effectively will be seeking a change in institutional behavior.

*This case scenario was adapted from the Ethics in Practice Column in PT-Magazine of Physical Therapy. This can be accessed online at <http://www.apta.org/Ethics/Tools/>. APTA member login-required.*

### Case Study #2<sup>9</sup>

Stephanie is in her fourth year serving as a contract physical therapist (PT) for a small K-8 school district she always has found to be very responsive to the needs of students and their parents. But she now finds herself in a difficult situation pertaining to one particular student.

Joey is 12 years old and in the 7th grade. He has a mild developmental disability and had been taught in special education classrooms until the fifth grade. Stephanie started seeing him when he was in fourth grade, working with his teacher to develop the gross motor skills he would need to mainstream into a regular classroom.

Joey remained on program with her twice a week during that transition year, and by the end of the fifth grade she felt he was ready for discharge. However, because he would be moving to middle school in the sixth grade, Stephanie was asked to keep him on for one more year. She agreed, feeling she could justify working with him toward higher-level, school-based goals. She requested and received assurances, however, that the sessions be reduced to once a week, and that Joey be discharged from physical therapy at the end of the sixth grade.

This plan was fine with Joey, who got along great with Stephanie and enjoyed their work together, but was tired of being teased by his classmates when she came to get him. By the end of the sixth grade, Joey could do everything, physically, in gym and during recess that his friends could do. He hardly was a superstar, and had no illusions of becoming captain of the football team, but he could hold his own in sports and recreational situations and felt he no longer needed physical therapy. When school let out in June and Joey bid goodbye to the sixth grade, Stephanie's year-end report stated that Joey had met all of his school-based goals. She recommended discharge, with no further goals indicated.

In September, however, Stephanie found Joey on her case list. She assumed an error had been made, and sent Patty, the coordinator of the school system's child study team for students with individualized education plans (IEPs), a quick note to remove Joey from physical therapy. Patty responded, however, that the team had decided to keep Joey on program for another year at the request of his mother, who'd been elected to the school board in the spring on a platform of higher service levels for all students, and had argued that Joey risked backsliding without continued physical therapy.

Upset, but controlled in her comments, Stephanie emphasized that she had no goals for Joey, who required no additional physical therapy. Patty replied firmly that surely there were things Stephanie could work on with Joey. Patty said she did not want Joey's case to go to a due process hearing—the likely result of a change in Joey's IEP to remove physical therapy from it.

As Stephanie sees it, she has two choices: either to acquiesce to the child study team's wishes or to stick to her previous determination and refuse to put Joey on the program. As she considers her options, Joey walks by with a couple of his classmates and gives her a big smile, unaware that he soon may be forced back into physical therapy sessions he no longer needs nor wants.

### **Step I: Recognize and define the ethical issue**

- Realm: Institutional, because of what Stephanie sees as child study team's inappropriate involvement in a matter subject to her

professional judgment. Stephanie's commitment to Joey the previous school year also places this situation within the individual realm.

- Individual process: Stephanie demonstrates moral sensitivity, but her moral courage is challenged as she weighs whether to challenge Joey's mother and the child study team.
- Implications for action: As the PT professional, Stephanie bears full responsibility for her decision and its ramifications, which may include unnecessary services to Joey and unfortunate social consequences for the teenager.
- Type of ethical situation: A distress for Stephanie, who is concerned that the child study team will press her to continue Joey's physical therapy.
- Barriers: Pressure from the child study team about the likelihood of a due process hearing if Joey is to be removed from physical therapy.

### **Step II: Reflect upon the situation**

- Major stakeholders: Stephanie, Joey, Joey's parents, the child study team—and also taxpayers, who foot the bill for Joey's IEP.
- Consequences of action or inaction: If Stephanie decides to challenge the child study team's decision, she must defend her stance to that group and potentially in a due process hearing, as well. If she simply acquiesces, on the other hand, she facilitates a path for other parents, in the future, to successfully push for continuation of physical therapy beyond demonstrated need.
- Laws broken? Quite possibly. Stephanie knows the educational relevance of continued physical therapy for Joey must be justified, as must her rationale for discharge. A due process hearing would clarify these issues.
- Professional guidance: Ethical principles 4 and 2—requiring sound professional judgment and trustworthiness toward patients, respectively—should particularly resonate with Stephanie. Also, the core values of integrity and professional duty.
- Right-versus wrong tests: Illegal? Again, this seems likely. Situation feels wrong? Yes. Discomfort if information becomes public? Yes. Your parents likely to take action in similar circumstances? Yes. Violations of APTA's professional codes and documents? Yes.

### **Step III: Decide what to do**

Action must be taken.

### **Step IV: Implement, evaluate, and reassess**

Regardless of the resolution of this situation, it would seem that a change in institutional policy or culture is needed to keep this from being a recurring scenario.

PTs in the schools often encounter difficulty fulfilling their dual roles as health care professionals in an educational setting. But the school-based PT first must adhere to the requirements of licensure, working with the child study team to help that panel fully understand the circumstances under which physical therapy is best provided.

*This case scenario was adapted from the Ethics in Practice Column in PT-Magazine of Physical Therapy. This can be accessed online at <http://www.apta.org/Ethics/Tools/>. APTA member login-required.*

The above case studies were presented in an open-ended format to promote questions and concerns versus offering a decision or providing recommendation. The true outcomes of such a situation would be contextual and influenced by state laws, regulations, etc.

## Section II: Patient Discharge vs. Abandonment

The patient-clinician interaction in physical therapy is unique, since physical therapists are intimately involved in a patient's medical care on a weekly basis. For the PT, the issue of patient abandonment can be confusing. In fact, PTs may be committing abandonment and not even know it. In this discussion, we will define abandonment and look at the legal and ethical challenges that surround this topic.

We will discuss these concerns and strategies in the context of insurance visit limits, but they should be applied to all aspects of physical therapy practice. All physical therapist have a legal and ethical duty to their patients and have an obligation to avoid acts of patient abandonment.

### Defining Patient Abandonment

A PT tells a patient that they have reached their insurance limits and further treatment cannot be rendered. Another PT terminates a relationship with a patient because they feel there is a conflict of interest (e.g. personal issues). In both cases, the PT made a decision without notifying the patient.<sup>10</sup> This qualifies as abandonment.

Patient abandonment refers to the removal of a patient's treatment without giving reasonable notice or providing a competent replacement.<sup>11</sup> This is considered a form of medical malpractice.

A state's courts may further define abandonment, as the California courts in the case of *Cole vs. Marshall* (2007) did in the following statement.<sup>12</sup>

*"abandonment of a case by a physician without sufficient notice or adequate excuse is a dereliction of duty, and if injury results there from, the physician may*

*be held liable in damages."* [*Cole v. Marshall Medical Center, 2007 Cal. App. Unpub. LEXIS 4490 (California Unpublished Opinions 2007)*]

As one can see, the legal definition of patient abandonment is clear: it involves a decision by the health professional to terminate care without notifying the patient. This lack of communication unfairly leaves the patient with no recourse. Avoiding any issues of abandonment includes constant disclosure and informing the patient through each phase of the rehabilitation process. The only legally acceptable alternative to patient abandonment is to fully inform the patient and provide alternatives in a reasonable time frame.

### Patient Remuneration

If a patient is abandoned, they may have legal recourse against the health professional under the premise of medical malpractice. This could also be applied in a physical therapy case where an act of abandonment was committed. Again, this varies state to state.

Surprisingly, the California Medical Practice Act does not contain a specific provision regarding patient abandonment: Section 2234 of California Medical Practice act addresses "unprofessional conduct" but does not clearly address the topic of patient abandonment.

The Medical Board of California's website provides the following guidelines:<sup>13</sup>

*Although a physician is allowed to sever or terminate the patient/physician relationship, in order to avoid allegations of patient abandonment (unprofessional conduct), a physician should notify patients of the following in writing when the physician wishes to discontinue care:*

- *The last day the physician will be available to render medical care, assuring the patient has been provided at least 15 days of emergency treatment and prescriptions before discontinuing the physician's availability.*
- *Alternative sources of medical care, i.e., refer patient to other physicians, by name, or to the local medical society's referral service.*
- *The information necessary to obtain the medical records compiled during the patient's care (whom to contact, how and where).*

If a patient pursues a case under medical malpractice, California has a limit of \$250,000 for non-economic (pain, suffering, inconvenience, physical impairment, disfigurement and other damages) losses.<sup>14</sup> While patients may be able to get more remuneration for other comprehensive damages, expenses, etc.,<sup>14</sup> the language in the California Medical Practice Act and remuneration limits may pose a challenge for patients who are seeking fair compensation for their loss.



## Duty and Ethics of the Physical Therapist

One of the main areas of concern in our profession is when a third-party payer stops paying for services. If a therapist terminates the care without offering a reasonable alternative, then an act of abandonment could have occurred.

When looking at this issue in the context of patient abandonment two things have to occur for it to be a valid argument: <sup>11</sup>

- The physical therapist was treating the patient and had a duty to continue.
- The physical therapist terminated the treatment prior to completion.

For example, a post-surgical patient in October 2016 was discharged from a PT office under the premise that “they could not help her anymore.” Her benefits had run out for the year and they discharged her on the last approved visit. This could be considered a form of abandonment. The PT office had a duty to the patient to offer her alternatives such as a cash based payment plan versus terminating treatment.

This case illustrates a breach of duty by the physical therapist, and also poses some serious ethical concerns. Looking at all the ethical concerns surrounding patient abandonment the foundational Belmont Principles of Respect, Beneficence, and Justice stand out. <sup>2,3,15</sup> (These principles, which will be discussed more fully in the next section, were originally created as a form of research ethics but can be applied to the issue of patient abandonment.)

In the case mentioned above, the principle of “respect” was clearly violated when the physical therapist discharged the patient under the premise of “we cannot help you anymore,” without even discussing options with the patient. Thus, the patient could not make an informed decision about their care. <sup>2,3,15</sup>

The principle of “beneficence” was violated since the physical therapist failed to do the best for the patient. In fact, they didn’t even call or provide any correspondence to the referring physician upon discharging the patient. The patient was left to seek their own answers. <sup>2,3,15</sup>

“Justice” was not met since the physical therapist discharged the patient on their last approved visit. This was confirmed when we verified the patient benefits for our facility. The patient should have been forewarned about her progress and offered options well before her insurance benefits had expired. <sup>2,3,15</sup>

### Risk Reduction and Solutions

The physical therapist can avoid any form of patient abandonment by giving the patient reasonable notice and alternatives. In the case we discussed above, for example, above, the patient should have been informed about her progress and visit limits prior to discharge.

A PT clinic may want to develop a policy regarding patient insurance limits and reasonable alternatives. Here are three recommendations for PTs:

- 1) The physical therapist must continually communicate with their patients through the whole rehabilitation process including current status, plan of care, and prognosis.
- 2) 3-5 visits prior to reaching insurance limits, the patient is referred to the billing department to discuss reasonable alternatives. This only applies to patients who need more skilled physical therapy beyond their insurance limits.
- 3) The patient receives a written summary of alternatives (e.g. cash plan, hospital, etc) from the clinic in order for them to make an autonomous, informed decision.

## Section III: Informed Consent

Informed consent is the foundation of safe, ethical medical care.

For the patient, informed consent can be defined as the process of authorizing medical treatment after discussing the nature of the treatment including: indications, risks, and benefits.<sup>5</sup> For physical therapists, informed consent should begin with reporting initial evaluation findings, proposed plan of care, and prognosis of treatment. Also, informed consent may include discussing the benefits, risks, alternatives, and potential outcomes for a specific manual treatment, modality, or therapeutic exercise regimen. The goal is to provide the patient with enough information to make intelligent autonomous decisions.<sup>5</sup>

In this discussion, we will explore the different ethical and legal aspects of informed consent as it relates to clinical practice and research. Then we will briefly explore the aspects of informed consent with individuals who have special circumstances.

### Clinical Practice

Especially in physical therapy practice, the ethics of informed consent should always reflect the needs of the patient. The Belmont Principles of Respect, Beneficence, and Justice should always be the foundation of informed consent. *Respect* for the patient is making sure they understand what is written or told to them regarding the examination finding and treatment plan. Honest disclosure of information to the patient reflects the idea of doing what is good (*beneficence*) and fair (*justice*) for them.<sup>5</sup>

Informed consent should be an ongoing process, especially as new interventions are introduced in each phase of rehabilitation or the plan of care is changed. As clinics and rehabilitation facilities become busier, clinicians may forget to talk to patients about their revised plan of care, leading to conflict between

patient expectations and what is communicated by the clinician. Ethical concerns can arise if patients are not completely informed about their treatment. For example, a PT performs spinal manipulation (Grade 5 mobilization) to the patient's lumbar spine without discussing the projected benefits and risks of the treatment. Considering the APTA Code of Ethics, this situation would be a violation of Principles #1, #3 & #4 (Core Value: Integrity) and Principles #2 & #5 (Core Value: Professional Duty). These principles reflect ethical care of the patient.

A study by Everett et al (2005), examined subjects' (N=25) understanding and satisfaction with the informed consent process.<sup>5</sup> They found that the primary concern with subjects was the amount of information provided. Subjects wanted more information on the procedure, potential risk, benefits, and alternatives. Suggestions included additional sources of education including a video of the procedure and informing patient's family members.<sup>1</sup> For physical therapists, these findings support the idea that informed consent begins the day of the evaluation and ends when the patient is discharged.

The principles behind informed consent may have different interpretations among physical therapy clinicians. This is why organizations such as The World Confederation of Physical Therapy have created guidelines for clinicians to follow. In June 2007, The World Confederation of Physical Therapy updated their "Declaration of Principles" for informed consent. Their expectation for the physical therapist is to provide a competent adult with the following information:<sup>5</sup>

- Description of the intervention/treatment to be provided
- A clear explanation of the risks which may be associated with the therapy
- Expected benefits from the therapy and anticipated time frames
- Anticipated costs and reasonable alternatives to the recommended therapy

These guidelines provide a common language for clinicians to follow when dealing with patients and informed consent.

The clinician should be aware of the legality of not informing a patient. Lack of informed consent may be considered professional negligence.<sup>5</sup> Professional negligence can be considered a breach of duty by the clinician. Below are some qualifications for professional negligence.<sup>5</sup>

- A duty of care was owed the patient by the clinician
- That duty of care was breached by clinician failure to conform to the relevant standard of medical care.

- The breach of the standard of care must be shown by expert testimony, or in the case of obvious errors, the negligent act speaks for itself without additional testimony.
- The breach of duty caused a direct injury or was the proximate cause of an injury to the patient.

Fortunately, legal claims for lack of informed consent are few. A study by CNA/HPSO, a large insurer of physical therapists, looked at physical therapy claims (total 1,464) from December 1st 1993 through March 31st, 2006 and found that claims for uninformed consent were less than 1% (total 2) of all claims.<sup>5</sup> The low incidences of claims seem to reflect the strong ethical values of our profession and the respect physical therapists have for patient autonomy and informed consent. Despite these low incidences, all clinicians should always be prepared to discuss the details when introducing new interventions or when changes in treatment are made.

The legal issues surrounding informed consent and professional negligence have caused many states to enforce this issue to ensure the patient completely understands. Each case is unique; however, landmark cases such as *Schloendorff v. The Society of the New York Hospital* (1914), *Tarasoff v Regents of the University of California* (1976), and *Catalano v. Moreland* (2002) have improved the standards of informed consent.<sup>5</sup> Cases such as these are enforcing the high ethical standards that are needed when providing information and ultimately protecting the patient.

## Informed Consent: Special Circumstances

Informed consent for children and other vulnerable populations should be considered "special circumstances" and needs to be handled appropriately in order to ensure that patient autonomy is met.

### Assent for a Child

Assent for children in research is a comprehensive subject that takes into account the child's assent, parental consent, principle of "minimal risk," the selected intervention, etc. The details of this topic are beyond the scope of this discussion. The reader is referred to more comprehensive references such as the CITI Collaborative Institutional Training Initiative ([www.citiprogram.org](http://www.citiprogram.org)) which covers the federal regulations for children involved in research.<sup>5</sup>

In brief, assent can be defined as the child's affirmative agreement to participate in research or clinical treatment.<sup>9</sup> For clinical treatment, the American Academy of Pediatrics (1995) published a policy statement of assent which defines assent as having the following key elements:<sup>5</sup>

- Helping the patient achieve a developmentally appropriate awareness of the nature of his or her condition and telling the patient what he or she

can expect with tests and treatment(s).

- Making a clinical assessment of the patients understanding of the situation and the factors influencing how he or she is responding.
- Soliciting an expression of the patient's willingness to accept the proposed care.

These standards reinforce the need for patient autonomy at all levels. Physical therapy interventions for minors should include the elements mentioned above and should begin during the initial evaluation. Serious ethical concerns can arise if all parties are not properly informed.

*NOTE FROM COURSE AUTHOR: I consider informed consent complete when the adult is present during the initial evaluation and follow-up re-evaluations and all parties come to an agreement. This provides a medium for all parties to discuss the patient's plan of care and for the family to make an "intelligent" decision.*

### Consent for Vulnerable Populations

Along with children, there are other patient populations that are considered vulnerable and have specific guidelines for clinical practice and research. Vulnerable populations include prisoners, pregnant women, fetuses, the elderly, cognitively impaired subjects, and other groups (e.g. illiterate, minorities) that can be considered exposed and require special handling to ensure appropriate informed consent is reached.<sup>5</sup>

In 2009, The Department of Health and Human Services updated the Code of Federal Regulations (45 CFR 46): Protection of Human Subjects which defines the federal policies for research.<sup>5</sup> These regulations have become a standard in research and are commonly enforced by institutional review boards. The overall purpose of these standards is to allow these populations to receive complete informed consent in a way that allows them to make an autonomous decision.

These guidelines should also be mirrored in the clinical setting. Every effort should be made to make sure that vulnerable populations understand the initial evaluation findings, proposed plan of care, and prognosis of treatment. For example, at the first visit a minority patient may need a translator or an elderly patient may need their legal guardian present in order to clearly communicate the information in order for them to make an autonomous informed decision. Clinicians should consider these vulnerable populations as special circumstances and make sure every action is taken to ensure the patient is able to make an informed decision.

## Section IV: Law Review

As we've seen, The American Physical Therapy Association (APTA) Code of Ethics defines PT practice by setting standard behavioral or moral expectations for PTs.

In the U.S., each state has their own PT practice act which is enforced by some type of state PT Board. These PT Boards interpret state laws related to the practice of PT and develop regulations to help define the practice of PT within those state laws.

Since state laws related to the practice of PT are often influenced by ethical standards, Boards also look to the APTA Code of Ethics to inform standards or codes of behavior for PTs.<sup>7</sup> Thus, laws and ethics are often discussed as interdependent topics.

### Laws vs. Regulations

It's important for clinicians to understand that there are two sections to state practice acts: Laws and Regulations. Each state has their individual definition of laws and regulations. For example, in the state of California these are clearly defined. Please see below:<sup>16</sup>

**Laws** are created by statutes that originate from legislative bills originally introduced by either the Senate or the Assembly. For example, in 1953 the Physical Therapy Practice Act (Act) was created by Chapter 1823 because of AB 1001. 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.<sup>16</sup>

**Regulations** are standards (see the Rulemaking Process below) adopted as rules by the Physical Therapy Board of California (PTBC) to implement, interpret, or make specific the law enforced or administered by the Physical Therapy Practice Act. Regulations must be approved by the Office of Administrative Law, and filed with the Secretary of State.<sup>16</sup>

Therefore, each state will have a specific practice act (e.g. laws) that defines the practice of physical therapy in that state. There may also be specific regulations from the state PT board that help define and clarify that state's practice act. It's important to understand your state's practice act and any specific regulations that apply to it in order to stay within your scope while treating patients.

The APTA website provides a listing of the state PT Boards which is available at:<sup>1</sup> <http://www.apta.org/Licensure/StatePracticeActs>.

### Common Legal Questions

This section reviews 10 common legal questions on current topics regarding the practice of physical

therapy. These questions may not pertain to every state; the reader is encouraged to consult their own state's practice act and relevant regulations, if further questions are warranted.

**What if I have a legal concern about the practice of physical therapy? What is my best source to contact?**

Often clinicians may seek information from the APTA regarding the practice of physical therapy in their state – but while the APTA provides a foundation for the profession by guiding ethical practice and establishing standards of care, it is not an absolute resource for state PT legal concerns. In this case, the best source may be to consult the PT board in the state where you practice.<sup>1</sup> In general, most state PT Board websites will have their practice act readily available for viewing along with any relevant regulations that help to clarify specific practice issues.

(The APTA website provides a listing of the state PT Boards which is available at: <http://www.apta.org/Licensure/StatePracticeActs>.)

**I took a series of APTA sponsored courses that covered Grade V joint mobilization and dry needling. Does that qualify me to do those procedures in my state?**

The APTA sponsorship confirms the highest quality of continuing education but does not guarantee state approval for rendering such services. In this case, the best source would be to consult the PT Board in the state where you practice. The two topics may have different practice limitations in different states, especially the use of spinal manipulation (Grade V mobilization). For example, two well-known cases in Alabama (*Teston v. Arkansas State Board of Chiropractic Examiners*<sup>17</sup> and *Dunning v. Alabama State Board of Chiropractic Examiners*<sup>18</sup>) have debated the use of spinal manipulation by physical therapists. Thus, it's important for clinicians to understand their state's PT practice act and any relevant regulations in order to avoid any legal practice violations.

**I am having problems with the insurance payers in my state. What is the best resource?**

In this case, the APTA would be the best resource since the website offers a comprehensive section on payment which covers most of the major insurance carriers including: Medicare, Medicaid, Worker's Compensation, and TRICARE.<sup>19</sup> The website is available at: <http://www.apta.org/Payment/>. The APTA helps members deal with insurance issues on the state and national levels. Members can also call or email them directly with specific questions. Other resources include your state's APTA chapter and directly contacting the insurance payer.<sup>19</sup>

**What if I have questions about supervising physical therapy students and/or physical**

**therapist assistants (PTAs), and billing for their services?**

In the case of supervising a student, both your state PT Board and the student's physical therapy program will be the best resources. Each state PT Board will have specific guidelines for the supervision and role of the physical therapy student, and the student's doctor of physical therapy (DPT) program will have specific guidelines for the student to follow.

In the case of supervising a PTA, your PT Board will be the best source of information. In general, most states have specific guidelines for supervision of both PTAs and aides. Ultimately, the supervised employee falls under the license of the PT thus specific supervision guidelines are necessary. For example, in California a PT can only supervise one PTA and one aide during patient care tasks. The PT Board of California does allow for supervision of two PTA's under specific circumstances.<sup>16</sup>

(The APTA website provides a listing of the state PT Boards which is available at <http://www.apta.org/Licensure/StatePracticeActs>.)

In the case of reimbursement, it's important for the clinician to be familiar with the supervision and reimbursement guidelines for each of the payers they contract with. For example, Medicare will only reimburse for services rendered by a licensed PT under Medicare Part B.<sup>19</sup> The APTA has a comprehensive section that discusses the role of the PT student, PTA, and aide under various insurance programs such as Medicare. It can be accessed at: <http://www.apta.org/Payment/>.

**What if I witness or have questions regarding a possible incident of abuse toward a patient? Who should I consult?**

Obviously, if there is imminent danger, the local authorities should be contacted immediately. All states provide some type of law and/or regulation that defines the role of health professionals as mandatory reporters. In this case, your PT Board will have this information available. Using the state of California as an example, the physical therapist must report any form of physical self-abuse, abuse to minors, and elderly abuse.<sup>16</sup> California requires an immediate phone call and a written report within two working days (children 36 hours).<sup>16</sup> Thus, it's imperative that the PT familiarize themselves with the laws pertaining to mandatory reporting in their state.

**Currently, my new graduate PTA does not perform any peripheral or spinal joint mobilizations but I want her to begin with my patients. Who do I consult regarding the ability for my PTA to do joint mobilization?**

A debate recently emerged when the Commission on Accreditation in Physical Therapy Education (CAPTE)



decided to allow PTA programs to teach the theory and clinical skills for grade I & II mobilizations. The APTA's position, however, is unchanged: it considers the intervention exclusive to physical therapists.

In this case, the best resource would be your state PT Board since they can interpret the role of the PTA within your state's practice act. It's important for clinicians to realize that the state practice acts may not provide specific language regarding joint mobilization performed by the PTA. Ultimately, the PTA functions under the license of the PT. Thus, the PT is ultimately responsible for patient safety when utilizing the services of a PTA for patient care. Comprehensive coverage and recommended guidelines for mobilization and manipulation can be accessed on the APTA website. Here is the link:<sup>20</sup> <http://www.apta.org/StateIssues/Manipulation/>

**I would like to provide wellness and fitness services to my clients. I also would like to provide nutritional plans for my clients. Who do I consult regarding the ability to provide these services as a PT?**

In the case of the first question, your state PT Board will be the best resource for answers. As PTs work in multiple settings, it's important to understand the scope of the PT license in your state and ultimately what types of services you are able to provide. Let's use California as an example: until 2005 PTs could not provide wellness and fitness services. The passage of SB 1485 allowed PTs to render such services.<sup>16</sup> More specifically, this allowed PTs to work in various fitness settings.

In the case of the second question, the regulations regarding nutritional counseling and other related services may vary between states. In California, there is a specific definition regarding nutritional advice (CAL. BPC. CODE § 2068). The statement is below:<sup>21</sup>

*"State law allows any person to provide nutritional advice or give advice concerning proper nutrition--which is the giving of advice as to the role of food and food ingredients, including dietary supplements. This state law does NOT confer authority to practice medicine or to undertake the diagnosis, prevention, treatment, or cure of any disease, pain, deformity, injury, or physical or mental condition and specifically does not authorize any person other than one who is a licensed health practitioner to state that any product might cure any disease, disorder, or condition."*

Thus, it's important for PTs to understand their state laws regarding nutritional and supplemental advice in order to stay within their scope of practice since providing such information could be mistaken as medical advice.

**I have direct access in my state and I want to start an internet/telehealth business for physical therapists. Who do I consult to find**

**out my legal boundaries?**

In this case, consulting the PT Board in your state would be the first step. Since the expansion of the internet and cell phone usage, the idea of telehealth (telemedicine) has become more popular. According to the Federation of State Medical Boards many states are creating legislation for such services. As of 2016 the following legislation has occurred:<sup>22</sup>

- Forty-eight (48) state boards, plus the medical boards of District of Columbia, Puerto Rico, and the Virgin Islands, require that physicians engaging in telemedicine are licensed in the state in which the patient is located.
- Fifteen (15) state boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine.
- Four (4) state boards require physicians to register if they wish to practice across state lines.
- Twenty-eight (28) states, plus the District of Columbia, require both private insurance companies and Medicaid to cover telemedicine services to the same extent as face-to-face consultations.
- Eighteen (18) states currently require only Medicaid to cover telemedicine services.
- One (1) state requires only private insurance companies to reimburse for services provided through telemedicine.

More states are allowing such services and are creating new legislation to address the issues surrounding telehealth. For example, California passed AB 415, providing clear guidelines for telemedicine.

As for physical therapists providing telehealth services, there is still specific licensure and payment policy barrier that may prevent PTs from providing such services. Thus, consulting with your state's PT Board would be the best initial step, as they can provide the most accurate information. A recent manuscript by Di Cerbo et al provides a good narrative overview of current telemedicine in the United States. The full-text article can be accessed at: <https://www.ncbi.nlm.nih.gov/pubmed/25609928>.

**I want to form a corporation with my fellow physical therapists. Who is the best resource to consult?**

In this case, the best source would be your state's PT Board: there may be specific provisions within the state's practice act that define a physical therapy corporation. Also, the state's business and professional codes will define the different corporate structures available for health professionals. The sources mentioned can help the clinician interpret the state's PT practice act and relevant laws as they pertain to

physical therapy corporations. Other resources include the state APTA chapter and consulting an attorney familiar with physical therapy corporations in your state.

### **I have concerns regarding the Physician Owned Physical Therapy (POPT) clinic that opened nearby. Who should I consult regarding my concerns?**

In this case, the APTA may be the best source to consult since they have comprehensive coverage of the referral for profit debate on the state and national level. Your state's PT Board may have information regarding PT's relationships with physicians and other health professionals.

The legal questions above are just a few of the emerging questions physical therapists may ask regarding legal issues in their state. The list of references at the end of this course is a good resource for additional discussion of these topics. The reader is also encouraged to consult their state PT Board on a regular basis to stay current with changes in laws and regulations. The APTA is also a great resource for issues regarding payment and POPTs at the state and national level. Last, the Federation of State Boards of Physical Therapy is another valuable resource regarding the national board exam, continuing competency, and questions from consumers. Their website is <https://www.fsbpt.org/>.

## **Conclusion**

This course provided the reader with a practical review of four topics.

First, PT ethics was discussed, reinforcing the moral standards by which clinicians practice. The ethical practice of PT is defined by the APTA Code of Ethics – this helps lawmakers establish state laws based upon these standards.

Second, we discussed the ethical and legal issues surrounding patient discharge versus abandonment. This is a particularly timely topic given the current healthcare constraints in the U.S.: patients run the risk of being discharged based upon their insurance restrictions, not their individual needs.

Third, we examined informed consent, an important aspect of patient centered care that honors the autonomy of the patient by making sure they understand all aspects of their treatment.

Fourth, a general law review was provided that discussed common aspects of state laws pertaining to the practice of PT. Remember, any and all of these laws may be informed by the APTA Code of Ethics.

The reader is encouraged to continue to study these subjects in order to have a complete understanding of their professional scope of practice.

## **Appendix A: Ethical Terms in Physical Therapy<sup>2,24</sup>**

**Absolute rights** – As the adjective would imply, these are rights that cannot be over-ridden, and are thus “unconditional,” regardless of competing moral claims or social conditions. It is not clear that such rights exist. Consider the right to life (and the duty to avoid killing). Common moral judgments about the justifiability of killing in self-defense, capital punishment, and killing in war condition the application of the right to life (and the duty to avoid killing) in almost all societies.

**Act utilitarianism** – Theory that the principle of utility is -- or ought to be -- applied to particular acts in particular circumstances. An act utilitarian justifies actions simply by direct appeal to the principle of utility. Contrast with rule utilitarianism.

**Altruism** – Regard for others. As a theory of action, this can be descriptive (i.e., that people do, at least sometimes, appear to act in other than self-regarding ways). Or it can be a normative position about how people ought to behave (viz., at least sometimes, people should act in non-self-regarding ways). Contrast with egoism.

**Applied ethics** – Use of ethical principles to describe or evaluate conduct in particular areas of society (e.g., biomedical ethics, business ethics, public policy ethics). In approach, applied ethics can be descriptive (how professions or sectors do conduct themselves) or normative (what one thinks are desirable behaviors for persons in particular professions or sectors).

**Autonomy** – The principle of respect for persons, and of individual self-determination consistent with that principle. As most commonly defined, autonomy points in the direction of personal liberty of action in accordance with a plan chosen only by oneself. In Kant's formulation, which reconciles with some difficulty with our usual individualistic views, autonomy is fully realized only when one governs oneself in accordance with universally valid moral principles.

**Beneficence** – Moral principle that one should help others further their important and legitimate interests, either as those persons understand them (respecting autonomy) or as we conceive them (paternalism). Under this principle, failure to increase the good of others when one is knowingly in a position to do so is morally wrong. Nonetheless, the principle is usually understood restrictively: in most theories, one is obligated to act to benefit others when one can do so with minimal risk, inconvenience or expense. (Formally, the principle or duty of beneficence corresponds to the virtue or human characteristic of benevolence; in common parlance, these terms are often used interchangeably.) See also nonmaleficence.

**Categorical imperatives** – Rules of conduct that stem from the Kantian principle that is a cousin of the Golden Rule: “I ought never to act except in such a way that I can also will that my maxim should become a universal law.” (Your parents probably had a related formulation with which to critique your behavior: “What if everyone acted that way?”) Kant’s candidates for categorical imperatives include “Help others in distress,” “Do not commit suicide,” and “Do not make false promises.” Kant is not a consequentialist: Something is “not good because of what it effects or accomplishes or because of its adequacy to achieve some proposed end,” but because of the principles that ground the act. Nonetheless, the “universalizability” maxim by which categorical imperatives are constructed is compatible with some justifications for rule utilitarianism.

**Character ethics** – Generally, a normative stance that gives priority to cultivation of character traits such as benevolence, honesty, compassion, faithfulness and courage. Character ethics takes the stance that specification of obligatory actions (i.e., what one should or should not do) is less important than the cultivation of these character traits. Also called virtue ethics.

**Civil disobedience** – Refusal to abide by some subset of the rules of the existing political-social order, because of a felt obligation to a different, higher standard. See e.g., natural law.

**Confidentiality** – The principle that one should keep one’s promises about information (re)disclosure. A subset of duties of fidelity.

**Deontological (non-consequentialist) theories** – Generally, a normative stance that views what should be done as determined by fundamental principles that do not derive solely or even primarily from consequences. An act or rule is right insofar as it satisfies the demands of some over-riding (non-consequentialist) principle of moral duty. Deontologists sometimes stress that the value of actions lies more in motives than in consequences. Religious revelation (“divine command”) is the historically common foundation for deontological moral principles: things are right or wrong if, and only if, commanded or forbidden by God. Natural law or human reason may also be cited as sources. For example, John Rawls’ Theory of Justice articulates a deontological approach based on appeal to a social contract, reached by rational participants under conditions of absolute fairness and equality. Some philosophers (and many sociobiologists) take the position that deontological principles are simply those that have “tested out” as having good consequences over a long period, and are accordingly sanctioned by custom, religious practice, etc.

**Descriptive ethics** – Factual description and explanation of moral behavior and beliefs (typically by anthropologists, sociologists, and historians); concerned with what is done. In general, this view approaches ethical standards as historical products sanctioned by custom. Compare with normative ethics.

**Duty** – Action, or an act, that is due by moral or legal obligation. Rights, grounded in core ethical principles such as autonomy, beneficence/nonmaleficence and justice, create duties -- either of non-interference (for negative rights) or for provision of social goods (positive rights). Duty need not be grounded only in the strong language of rights. Day-to-day social interactions also give rise to notions of duty: promises create duties of fidelity, gifts create duties of gratitude, and so forth. Many moral philosophers have argued that participation in a political-social system creates a duty to abide by its laws and standards (but see civil disobedience).

**Egalitarian theories** – Theories of ethics which stress equal access to important social goods, based on giving primacy to principles of social justice. Contrast with libertarian theories.

**Egoism** – Stance that all human choices do (or should) involve self-promotion as their sole objective. Psychological egoism is the descriptive version, contending that people usually do what is in their self-interest. A strong version of the theory would contend that we psychologically cannot ever act voluntarily against what we believe to be our own best interest. Any apparently altruistic act stems from a belief that the conduct promotes the individual’s long-run self-interest. (Individuals may have inadequate or inaccurate information, and so may make mistakes.) This is essentially the behavioral theory that underlies market economics -- although even hard-core free marketeers would allow for a “taste” for altruism. Ethical egoism goes beyond a theory of motivation to a normative position that people ought to desire their own well-being (and, in a strong theory, only their own well-being), as an end in itself. Sociobiological theories of what might be called “genetic egoism” are compatible with altruism that promotes group survival (that is, survival of group genetic material in subsequent generations).

**Equality** – Some of the most difficult questions of ethics arise over how to specify and prioritize among the relevant characteristics by which people are to be considered equal or unequal. Since every individual is an amalgam of many “characteristics,” even interpersonal decisions about equality and inequality require setting priorities about which is/are to be considered most important. (The problem is all the greater when attempting to compare groups, for obvious reasons.) Will it be need, effort, ability or some other variable that sets the terms of the distribution? The answer will often depend on the context of the question. See also justice.



**Existentialism** – Stance that choices and commitments must ultimately be made by each individual alone, and that the individual must thereafter accept responsibility for the choice, abandoning any hope for some higher level of justification (such as God). Most famously presented in the work of Jean-Paul Sartre: “Man makes himself. He isn’t ready-made from the start. In choosing his ethics, he makes himself, and the force of circumstances is such that he cannot abstain from choosing” (from *Essays on Existentialism*).

**Facts and values** – Bifurcation of the world into statements about what is (facts) and what ought to be (values). The division is by no means universally accepted; and those that accept the division are not necessarily in close agreement on the dividing line. One of the central controversies of moral philosophy is whether value judgements (including moral judgements) can ultimately be proved, verified or justified in terms of facts or rational reasoning. Many important ethical schools of thought split over the details of this issue, as in the positions of descriptivism, intuitionism, naturalism, noncognitivism, and prescriptivism (descriptions of which are beyond the scope of this glossary).

**Feminist theories** – Ethics from a feminist perspective places emphasis on “care,” and so is sometimes referred to as “care ethics.” It sees itself as a challenge to the dominant (and male-biased) deontological and consequentialist approaches. (But see also character ethics as another form of challenge.) Feminist ethical theories emphasize the importance of relationships in morality (rather than the paradigm of isolated individuals seen in some ethical traditions), and give greater weight to emotions (in contrast to the emphasis on rationalism of some traditional approaches).

**Fidelity** – The principle that one should keep one’s promises.

**Human reason** – For some schools of ethics, human rationality provides the ultimate (and only) grounding of ethical principles; for others, it is the last thing on which one should place reliance.

**Justice** – Commonly described as fairness, but more closely aligned to the concept of “desert” (pronounced like, but not to be confused with, “dessert” of the ice-cream et al variety): One has acted justly toward a person when one gives that person what is due or owed, and therefore what is deserved. Common to all definitions of justice is the minimal principle that relevantly similar cases (persons) be treated alike. Unfortunately, the definition of “relevantly similar” is not always self-evident. Some of the most intractable questions about justice arise over how to specify and prioritize among the relevant characteristics by which people are to be considered equal or unequal. (Consider affirmative action.) Moreover, the principle

of “treat equals equally” leaves unanswered the question of appropriate differences in treatment, when relevant dissimilarities are found to exist. The term “distributive justice” refers, more restrictively, to the distribution of social benefits and burdens; “retributive justice” applies to issues of correction and punishment; “procedural justice” refers to social processes (most familiarly, in the judicial system). Egalitarian theories of justice stress equal access to primary social goods; libertarian theories of justice give primacy to social and economic freedom; Marxist theories emphasize need (“to each according to his needs; from each according to his abilities”); utilitarian theories are focused on criteria to maximize well-being; and so on.

**Libertarian theories** – Ethical approach stressing social and economic liberty, grounded on the primacy of the principle of autonomy.

**Liberty** – Freedom of human action, grounded in the principle of autonomy, consistent with the nature and dignity of human beings. It is generally accepted that some liberties may be judiciously traded off for state protection via the law. As with the specification of justice, reasonable persons may differ markedly on the details of such liberty trade-offs, as may particular societies. Philosophers who have taken a darker view of human beings (e.g., Thos. Hobbes), or who place a higher value on community (e.g., J. J. Rousseau) are inclined to opt for more circumscription of liberty than those who see liberty as pre-eminently important and humans as fundamentally rational, good-natured sorts. (John Locke and our own Founding Fathers are examples of the latter view). See also liberty-limiting principles, social contract.

**Metaethics** – Analysis of central ethical terms, such as “right,” “obligation,” “good,” “virtue,” “responsibility,” etc., and of the structure of logic of moral reasoning, moral justifications and inferences. Can be descriptive or normative in its approach.

**Morality (ethics)** – The science of human duty; the rules of human conduct. The function of morality is “to combat the deleterious consequences of human sympathies” (Beauchamp). Its aim is “to contribute to betterment -- or at least non-deterioration -- of the human predicament” (Warnock). “Ethics aims at discovering what are those other properties belonging to all things which are good” (Moore). Moral/ethical principles have the following characteristics, in most but not all formulations: They are (1) supremely authoritative or over-riding as a guide to action; (2) prescriptive, not merely descriptive; and (3) universalizable, to relevantly similar situations. (But see also relativism, as regards the last of these.)

**Natural law** – Standards binding on all persons, and taking precedence over particular standards created by human convention. Natural law can be based on a concept of the natural order (e.g., in Greek philosophy)



or as derivative of divine reason (e.g., in Christian philosophy). From a natural law stance, conventional (human societies') laws should ideally reflect natural law dictates; when they conflict, natural law trumps conventional law. (Conventional authorities, such as the police and courts, may nonetheless enforce the conventional law whether it is congruent with natural law or not. This leads to the issues of civil disobedience and political obligation.

**Natural rights** – Natural rights can be viewed as particular expression of natural law. Natural rights are those due equally to all individuals, and so possessed by persons whether or not the rights have been recognized by their particular political-social system. For Locke, life, liberty and property were the top three categories; our Declaration of Independence famously lists life, liberty and the pursuit of happiness. The Bill of Rights can also be viewed as a list of natural rights (speech, conscience, association, due process, etc.), given form in the language of our constitution.

**Naturalism** – Theory that value judgements can be justified through marshalling factual evidence. In this view, values are a type of fact; they refer to natural properties ("a natural thing"). Naturalists do not necessarily hold that a value exists independently in nature, or apart from what humans value; but, given particular bio-socio-cultural facts, they believe the content of values can be "tied down." A naturalist Darwin might contend that "right" means "conforming to the course of human evolution" (as would a sociobiologist like E. O. Wilson); a naturalist Mill or Bentham, from the utilitarian camp, might understand evil as "causing displeasure or pain." Critics of naturalism say you can never get from an "is" (fact) to an "ought" (value), without introducing another "ought." For example, they'd say that labeling "conforming to the course of human evolution" as right is a value judgement; likewise labeling displeasure or pain as a bad thing is a value judgement, even if that seems axiomatic. See naturalistic fallacy.

**Nonmaleficence** – Moral principle that one should refrain from harming others ("first, do no harm"). Compare with beneficence.

**Normative ethics** – The philosophical attempt to formulate and defend basic moral principles and virtues governing the "moral life"; concerned with what ought to be done. In general, this approach aims at some core of universalizable right and wrong (which may be narrow or all-encompassing, depending on the formulation). Contrast with descriptive ethics.

**Obligations** – See duty.

**Obligatory acts** – See duty. Contrast with supererogatory acts.

**Original position** – Hypothetical pre-social position (see esp., John Rawls' Theory of Justice) of persons who are creating a social contract. See also veil of ignorance.

**Paternalism** – Stance that a person's liberty is justifiably restricted to prevent self-harm, or to promote that person's own well-being. Paternalism is an inherently liberty-limiting principle. It is grounded in a theory of impairment, viz., that an individual lacks sufficient facts or mental capacity to make a sound choice. It is sometimes defended by a theory of future consent: viz., that the person whose liberty is circumscribed will (or, at least in principle, could) eventually agree that the restriction was desirable, given better facts or improved cognitive capacity in future.

**Pluralism** – Position that there is no single ethical theory or single method for resolving all disagreements, since moral principles can collide and reasonable persons can disagree about how to resolve the collision (e.g., differences about the value of liberty vs equality). Pluralistic theories are contrasted with monistic theories (that envision one supreme moral principle). The pluralist position is that in a heterogeneous culture there may be many sources of moral value and consequently a multitude of moral points of view on many issues (consider abortion). This applies all the more strongly across cultures, which may have much different "weightings" of principles, or indeed different principles entirely. See also relativism.

**Political obligation** – What is owed, in the form of obedience, to the laws and norms of the existing political-social order. See civil disobedience and natural law.

**Relativism** – Position that moral beliefs and principles are relative to individual cultures or, in the extreme, individual persons. Rightness and wrongness thus vary from place to place (even person to person); there are thus no (or at least few) absolute or universal moral standards that could apply to all at all times. Consequently, concepts of rightness and wrongness are meaningless apart from the specific contexts in which they arise. See also pluralism.

**Rights** – That which is due to individuals, based on core ethical principles. Rights create parallel duties on the part of others, or on society as a whole. So-called negative rights are rights of non-interference (e.g., with one's speech, conscience, associations), typically grounded in the principle of autonomy. Positive rights, by contrast, are rights of "recipience" (e.g., to education, health care), typically grounded in the principle of justice.

**Rule deontology** – Theory that non-consequentialist principles must be applied in the form of rules, and that such rules determine whether particular acts are right or wrong. Contrast with act deontology. See also act utilitarianism, rule utilitarianism.

**Rule utilitarianism** – Theory that the principle of utility is (or ought to be) the source of rules of conduct, and that such rules determine whether

particular acts are right or wrong. Rules justified by their general utilitarian consequences may nonetheless require actions that do not maximize utility in particular circumstances. The justification is that, despite such cases, overall utility is maximized by a rule-following system, compared to the alternative of having individuals decide on conduct in particular circumstances. Human beings have a notoriously difficult time being impartial about utility (or anything else) in matters involving their self-interest. Rules have the virtue of imposing a degree of “objectivity” by virtue of their inflexibility. Consistency requires that rules be applied in the same way to relevantly similar circumstances. Unfortunately, what is relevantly similar is not always clear. Contrast with act utilitarianism. See also act deontology, rule deontology.

**Self-determination** – See autonomy.

**Social contract** – A thought experiment to evaluate social and political rules. In a hypothetical pre-social state, one picks the rules that will structure the political-social order to come. In Thos. Hobbes’ famous rendering, the pre-social state is one of anarchy (humans are violent animals, and life is “nasty, brutish and short”); this justifies an authoritarian state. In John Locke’s kinder, gentler version, we are rational and essentially non-violent creatures, which justifies only a much more liberty-friendly political arrangement. In John Rawls’ influential Theory of Justice, moral principles are derived from such an approach: they are the principles to which free and rational persons would agree, from an initial state (original position) emphasizing equality. In an original position of equality, we are inclined to make up rules that are fair to all, because we do not know what particular social circumstances will be our lot. See also veil of ignorance.

**Supererogatory acts** – Acts over and above the call of duty, undertaken because of one’s personal ideals. Contrasted with morally obligatory acts (required by moral duty).

**Teleological theories** – See consequentialist theories.

**Universal law** – In Kant’s version of deontological ethics, one “ought never to act except in such a way that [one] can also will that [the] maxim should become a universal law.” That is, one should act in a way such that one would wish to see the rule or principle underlying a moral choice applied to all relevantly similar circumstances. See deontological theories and rule utilitarianism.

**Universalizability** – Criterion that moral judgements, principles and ideals should apply in a similar way to all persons in relevantly similar circumstances.

**Utility** – Happiness, pleasure, good consequences. In J. S. Mill’s formulation, “actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness.”

**Utilitarianism** – A conception of the moral life in terms of means-to-ends reasoning. An act or rule is right insofar as it produces or leads to the maximization of good consequences (utility). See act utilitarianism and rule utilitarianism.

**Veil of ignorance** – A hypothetical mental state, in John Rawls’ version of social contract theory, in which we are ignorant (at least momentarily) of our particular characteristics: sex, race, IQ, family background, etc. Valid principles of justice are those to which we would agree if we could freely and impartially consider the social situation, from an original position of such ignorance.

**Veracity** – The principle that one should tell the truth (“honesty is the best policy”).

**Vices** – Negative ethical/character traits. Contrast with virtues.

**Virtue ethics** – See character ethics.

**Virtues** – Positive ethical/character traits, such as benevolence, confidentiality, fairness, faithfulness, gratefulness, non-deceptiveness (truthfulness), nonmalevolence. Virtues correspond to principles or duties: beneficence, confidentiality, justice, fidelity, gratitude, non-deception (veracity), nonmaleficence, etc.

## Appendix B: APTA Code of Ethics Principles

### *American Physical Therapy Association Ethics Principles*

Available at <http://www.apta.org>

Publish Date July 1st, 2010<sup>6</sup>

<b>Principle #1: Physical therapists shall respect the inherent dignity and rights of all individuals.</b>	
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.	Ph All therapists shall recognize their personal biases and shall not discriminate against others in physical therapist practice, consultation, education, research, and administration.
<i>(Core Values: Compassion, Integrity)</i>	

<b>Principle #2: Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients/clients.</b>	
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.
<i>(Core Values: Altruism, Compassion, Professional Duty)</i>	

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

<b>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.</b>	
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.
<i>(Core Value: Integrity)</i>	

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

<b>Principle #6: Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors.</b>	
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.
<i>(Core Value: Excellence)</i>	



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

<b>Principle #8: Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally.</b>	
8A.	Physical therapists shall provide <i>pro bono</i> 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.
<b>(Core Values: Social Responsibility)</b>	

Proviso: The Code of Ethics as substituted will take effect July 1, 2010, to allow for education of APTA members and non-members.

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# LAWS AND ETHICS FOR THE PHYSICAL THERAPIST

(2 CE Hours)

## FINAL EXAM

1. \_\_\_\_\_ can be defined as follows: “The branch of philosophy that defines what is good for the individual and for society and establishes the nature of obligations, or duties, that people owe themselves and one another.”
  - a. Ethics
  - b. Morals
  - c. Professionalism
  - d. Right vs. wrong
2. The American Physical Therapy Association (APTA)’s Code of Ethics defines the practice of physical therapy on all levels, including \_\_\_\_\_.
  - a. Judicial, state, and executive levels
  - b. Personal, judicial, and state levels
  - c. Personal, organizational, and societal levels
  - d. State, national, and international levels
3. Which of the following is NOT one of the purposes of the American Physical Therapy Association (APTA)’s Code of Ethics?
  - a. Define the ethical principles that form the foundation of physical therapist practice in patient/client management, consultation, education, research, and administration
  - b. 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
  - c. Establish the standards by which the American Physical Therapy Association can determine if a physical therapist has engaged in unethical conduct
  - d. Interpret state laws related to the practice of physical therapy, and develop regulations to help define the practice of physical therapy within those state laws
4. The American Physical Therapy Association (APTA)’s Code of Ethics is based upon five key areas of physical therapy practice. It is also shaped by a set of \_\_\_\_\_ principles and seven core values.
  - a. 5
  - b. 8
  - c. 9
  - d. 12
5. Which 7 core values shape the American Physical Therapy Association (APTA)’s Code of Ethics?
  - a. Accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility
  - b. Accountability, altruism, compensation, excellence, integrity, professional liability, and social liability
  - c. Responsibility, humanity, compassion/caring, excellence, integrity, professional duty, and social respect
  - d. Responsibility, philanthropy, compassion/caring, excellence, integrity, professional morals, and social ethics
6. What are the four steps in the Realm-Individual Process-Situation (RIPS) Model of Ethical Decision Making?
  - a. Recognize, Decide, Reorganize, Consult Co-workers
  - b. Recognize, Reflect, Decide, Implement & Evaluate
  - c. Replicate, Decide, Reorganize, Consult Co-workers
  - d. Replicate, Reflect, Decide, Implement & Evaluate
7. Step I of the Realm-Individual Process-Situation (RIPS) Model of Ethical Decision Making consists of 3 components: \_\_\_\_\_.
  - a. Context, Stakeholders, Consequences
  - b. Ends-based, Rule-based, Care-based
  - c. Realm, Individual Process, Ethical Situation
  - d. Role-play, Prepare, Imagine
8. \_\_\_\_\_ refers to the removal of a patient’s treatment without giving reasonable notice or providing a competent replacement, and is considered a form of medical malpractice.
  - a. Expedited discharge
  - b. Limitations of care
  - c. Patient abandonment
  - d. Restricted disclosure

9. Which of the following is NOT a recommended way for physical therapists to avoid patient abandonment claims?
- 3-5 visits prior to reaching insurance limits, the patient is referred to the billing department to discuss reasonable alternatives (this only applies to patients who need more skilled physical therapy beyond their insurance limits)
  - The patient receives a written summary of alternatives (e.g. cash plan, hospital, etc) from the clinic in order for them to make an autonomous, informed decision
  - The physical therapist must continually communicate with their patients through the whole rehabilitation process including current status, plan of care, and prognosis
  - When a third-party payer stops paying for services, the physical therapist must terminate the care without notice
10. For the patient, informed consent can be defined as \_\_\_\_\_.
- An action, or an act, that is due by moral or legal obligation
  - The process of authorizing medical treatment after discussing the nature of the treatment including: indications, risks, and benefits
  - The principle that one should keep one's promises about information (re)disclosure
  - The stance that choices and commitments must ultimately be made by each individual alone
11. Informed consent for children and other vulnerable populations should be considered \_\_\_\_\_.
- Medically inadvisable
  - Null and void
  - Optional
  - Special circumstances
12. The best resource for concerns regarding the physical therapy laws and regulations that impact an individual licensee is \_\_\_\_\_.
- The American Occupational Therapy Association
  - The American Physical Therapy Association
  - The Federation of State Boards of Physical Therapy
  - The physical therapy board in their state
13. The best resource if you are having problems with the insurance payers in your state is \_\_\_\_\_.
- The American Physical Therapy Association, and the insurance companies
  - The Center for Medicare and Medicaid
  - The local authorities
  - Your state physical therapy board, and the state governor's office
14. The best resource if you have questions regarding direct access and offering nutrition services is \_\_\_\_\_.
- The American Physical Therapy Association
  - The Center for Medicare and Medicaid
  - The local chapter of the American Physical Therapy Association
  - Your state physical therapy board
15. The best resource if you want to form a corporation with a chiropractor and physician and need some advice is \_\_\_\_\_.
- The American Physical Therapy Association
  - The Center for Medicare and Medicaid
  - The local chapter of the American Physical Therapy Association
  - Your state physical therapy board



## ANSWER SHEET

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Country: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

License/certification # and issuing state/organization \_\_\_\_\_

Clinical Fellow: Supervisor name and license/certification # \_\_\_\_\_

Graduate Student: University name and expected graduation date \_\_\_\_\_

\*\* See instructions on the cover page to submit your exams and pay for your course.

**By submitting this final exam for grading, I hereby certify that I have spent the required time to study this course material and that I have personally completed each module/session of instruction.**

### Laws and Ethics for the Physical Therapist Final Exam

- |                    |                    |                    |                     |                     |
|--------------------|--------------------|--------------------|---------------------|---------------------|
| 1. (A) (B) (C) (D) | 4. (A) (B) (C) (D) | 7. (A) (B) (C) (D) | 10. (A) (B) (C) (D) | 13. (A) (B) (C) (D) |
| 2. (A) (B) (C) (D) | 5. (A) (B) (C) (D) | 8. (A) (B) (C) (D) | 11. (A) (B) (C) (D) | 14. (A) (B) (C) (D) |
| 3. (A) (B) (C) (D) | 6. (A) (B) (C) (D) | 9. (A) (B) (C) (D) | 12. (A) (B) (C) (D) | 15. (A) (B) (C) (D) |

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# Laws and Ethics for the Physical Therapist

## (2 CE HOURS)

### COURSE EVALUATION

Learner Name: \_\_\_\_\_

	Disagree				Agree	
	1	2	3	4	5	
Orientation was thorough and clear	1	2	3	4	5	
Instructional personnel disclosures were readily available and clearly stated	1	2	3	4	5	
Learning objectives were clearly stated	1	2	3	4	5	
Completion requirements were clearly stated	1	2	3	4	5	
Content was well-organized	1	2	3	4	5	
Content was at or above entry-level knowledge	1	2	3	4	5	
Content was substantiated through use of references, footnotes, etc.	1	2	3	4	5	
Content reflected stated learning objectives	1	2	3	4	5	
Exam assessed stated learning objectives	1	2	3	4	5	
Exam was graded promptly	1	2	3	4	5	
Satisfied with learning experience	1	2	3	4	5	
Satisfied with customer service (if applicable)	1	2	3	4	5	n/a

What suggestions do you have to improve this program, if any?

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What educational needs do you currently have?

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What other courses or topics are of interest to you?

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